

**State of Nevada**

**Department of Health and Human Services  
Division of Health Care Financing and Policy**

**Nevada's Comprehensive Care Waiver**

**Section 1115 Medicaid Research and  
Demonstration Project Waiver Request**

**April 19, 2012**

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## EXECUTIVE SUMMARY

The need for coordinated care for specific segments of Nevada's Medicaid population has become apparent over recent years, yet most of these high-need, high-cost recipients are not currently receiving any care management services. Most of these recipients have complex medical and social needs complicated by chronic diseases and multiple co-morbidities. In addition, this population has a high rate of behavioral health diagnoses and a risk of non-compliance with medications. Not only does this result in an overuse of expensive and avoidable medical services (like the emergency room), but it also leads to a poorer quality of life for these recipients. With the significant expansion of Medicaid in 2014, as part of the Patient Protection and Affordable Care Act (ACA), this problem will get worse without interventions.

To help address this issue, Nevada plans to expand the use of managed care strategies through a variety of delivery system modifications and payment reforms. Improving health outcomes and reducing Medicaid expenses in Nevada's unique health environment requires innovation and flexibility.

### **Proposed Solution**

In Nevada's Medicaid fee-for-service (FFS) population, the State will implement mandatory care management programs for those with chronic conditions or high utilization patterns. The overall goal is to provide the greatest degree of flexibility necessary in order to target programs to specific populations based on their medical needs through: innovative provider reimbursement and care delivery models; benefits design; increased use of Medicaid medical homes/health homes, and meaningful use of electronic health records. In Nevada's Medicaid managed care (MCO) population, the State will develop systems that will expedite enrollment in the managed care organization to better enable consistency of care and care management processes. Below are Nevada's phased goals for the Section 1115 Research and Demonstration Project Waiver, called the Nevada Comprehensive Care Waiver (NCCW).

**Phase One** would provide specific Medicaid FFS recipients with high-care needs, and who are not currently receiving case management assistance, with care management services.

- September 2012: Implement a Care Management Organization (CMO) to cover the Medicaid FFS population, except for those receiving services through the Targeted Case Management (TCM) services, the Home and Community-Based Services Waivers (HCBW) or the Child Welfare system. Those populations are excluded, as they already receive case management services. Dual-eligible (Medicare/Medicaid) populations would also be excluded until Phase Two, when the State will work with CMS to determine if it would be beneficial to participate in the State Demonstration to Integrate Care for Dual Eligible Individuals initiative.

The CMO would also provide the infrastructure needed to help small medical practices become Medicaid medical homes or health homes. This will be done by creating a care management system that develops linkages between community resources as well as networking with other providers and utilizes electronic health information and data sharing tools, which will allow medical professionals to coordinate with other providers and achieve outcome measures.

- September 2012 and ongoing: Create Medicaid medical home and health home pilots across the state. The initial population will focus on both persons with chronic conditions as listed in Section 2703 of the ACA, and other recipients with high service utilization metrics who could potentially benefit from care management services. Payments will be structured on a per-member-per-month (PMPM) basis, with increased payments stemming from shared savings.

In locations where both medical/health homes and the CMO services are available, Medicaid FFS recipients would be able to choose which program they would like to participate in.

Additionally, Phase One would modify enrollment periods for Medicaid Managed Care Organization (MCO) recipients. Nevada is requesting the authorization, but not the immediate obligation, to require new TANF and CHAP recipients to choose a Medicaid MCO as part of their eligibility application or be auto-assigned immediately upon approval of Medicaid eligibility. Recipients would be allowed a 90-day period to change MCOs without cause.

- July 2012: Eliminate MCO selection periods in certain situations for recipients currently subject to mandatory enrollment in an MCO

**Phase Two** could expand Phase One by providing care management to all Medicaid FFS recipients who have increased care needs. The State will evaluate the results of Phase One to determine which methods were most successful (i.e. the Care Management Organization, medical/health homes and/or MCOs). Benefit plans will also be developed that encourage the use of the proper level of care and that trigger assistance when recipients are determined at risk and to have high care needs.

- July 2013: Implement Capped Benefits unless recipients participate in care management.
- September 2013 (sooner if able): Explore the possibility of adopting integrated care program(s) for the Dual Eligible population. Nevada submitted a letter of intent to work with CMS to determine if integration and shared savings under the State Demonstration to Integrate Care for Dual Eligible Individuals initiative would be beneficial to the State.
- September 2013: Expand care management to the referenced excluded populations (TCM, HCBW, and Child Welfare). In some cases, the HCBW care management also

serves as the HCBW eligibility service that enables individuals to gain HCBW eligibility and State Plan Personal Care Services (PCS). Nevada will consider consolidating all HCBW services into one pool. This may require moving the 1915 (c) programs under the NCCW. Consolidating services will ensure a coordinated, comprehensive (non-duplicative), and high quality care management program.

If the program successfully improves outcomes and decreases costs, then Nevada's long-term goal is to expand care management to all Medicaid recipients who would benefit from the services.

## **BACKGROUND**

### **History and Program Organization**

In 1965, Congress established the Medicare and Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act (the Act). Title XIX of The Act is a program that provides medical assistance for certain individuals and families with low incomes and resources. Medicare, Title XVIII of the Act, was also established in 1965 to address the specific medical care needs of the elderly (with the coverage being expanded in 1973 for certain persons with disabilities and/or with kidney disease). Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance. It is a jointly funded cooperative venture between the federal and state governments to assist states in the provision of adequate medical care to eligible needy persons.

The Nevada Department of Human Resources was created in 1963. During the 2005 Legislative Session, the Department was renamed the Department of Health and Human Services (DHHS). The Department's mission is to promote the health and well-being of Nevadans through services to ensure families are strengthened, public health is protected, and individuals achieve their highest level of self-sufficiency. Nevada adopted the Medicaid program in 1967 with the passage of state legislation placing the Medicaid program in the Division of Welfare and Supportive Services (DWSS). During the 1997 legislative session, the Division of Health Care Financing and Policy (DHCFP) was created.

### **Single State Medicaid Agency – Department of Health and Human Services**

The DHHS was designated as the single State agency for the Nevada Medicaid program. The Director of DHHS has the authority to make commitments with the federal government on behalf of Nevada. The Director is appointed by, and reports to, the Governor. Within the DHHS are the DHCFP, the DWSS, the Aging and Disability Services Division (ADSD), the Division of Mental Health and Developmental Services (MHDS), the Division of Child and Family Services (DCFS)

and the Division of Health (Health). This request for the NCCW is submitted by DHHS. The DHCFP will be responsible for the day-to-day management of the NCCW.

### **Division of Health Care Financing and Policy**

The mission of the DHCFP is to purchase and provide quality health care services to low-income Nevadans in the most efficient manner; promote equal access to health care at an affordable cost to the taxpayers of Nevada; restrain the growth of health care costs; and review Medicaid and other state health care programs to maximize potential federal revenue. The DHCFP administers the Medicaid and Nevada Check Up (Nevada's Children's Health Insurance Program or CHIP) programs.

Medicaid is administered in accordance with the applicable Title XIX State Plan, the Act, applicable Code of Federal Regulations (CFRs) and, the United States Code (USC), as well as all applicable Nevada Revised Statutes (NRS) and the Nevada Administrative Code (NAC). The DHCFP may adopt such regulations and policies as deemed necessary and may also amend the Title XIX State Plan, or develop Medicaid waivers in accordance with federal law, as necessary for the effective administration of Nevada's Medicaid program. The NCCW will allow Nevada flexibility to determine how to provide cost-effective and high quality benefits to Medicaid recipients.

Nevada operates both a FFS system and risk-based managed care delivery system. Enrollment in a managed care organization is mandatory for certain recipients who live in urban Clark and Washoe Counties. The DHCFP also contracts with a fiscal agent for FFS claims processing and related functions. This fiscal agent acts like a Quality Improvement Organization (QIO) for payment authorization, concurrent and retrospective review and related functions. The State's fiscal agent also performs enrollment broker-like activities. Services provided by other independent contractors include external quality review, actuarial services, non-emergency transportation (NET) services, and other clinical and administrative services.

### **Other DHHS Divisions**

Eligibility and enrollment functions for Nevada Medicaid are the responsibility of the DWSS. The DWSS determines Medicaid enrollee eligibility and maintains the eligibility system for the State's Medicaid program.

In addition, the Medicaid program includes four (4) Home and Community Based Services Waiver (HCBW) programs. The DHCFP works closely with other DHHS divisions to administer these programs. Nevada's current HCBW programs are as follows:

- Waiver for Persons with Mental Retardation and Related Conditions – Administered by DHCFP and operated by MHDS;

- Waiver for the Frail Elderly – this waiver includes Elderly who are in Adult Residential Care, as well as Elderly who are at home Administered by DHCFP and operated by ADSD;
- Waiver for Persons with Physical Disabilities – Administered and operated by DHCFP; and
- Assisted Living Waiver – Administered by DHCFP and operated by ADSD.

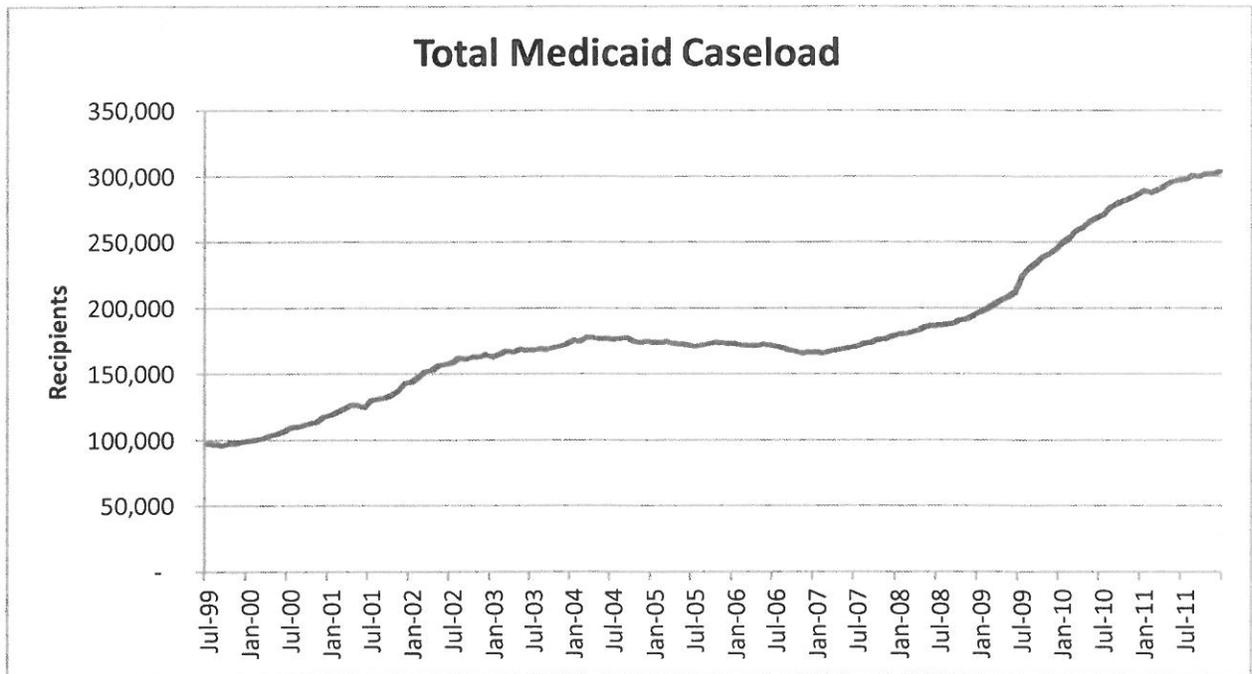
### **Imperatives for Medicaid Reforms**

Nevada is grappling with many of the same issues confronting other State Medicaid programs when it comes to how best to effectively and efficiently care for the Medicaid population. Medicaid agencies across the nation have implemented various forms of care coordination or care management initiatives – be it risk-based managed care, Primary Care Case Management (PCCM), disease management, or other forms of care coordination. While Nevada Medicaid has operated a traditional capitated managed care program, the state currently has only two managed care contractors who serve relatively low-cost Medicaid clients in limited geographic areas.

### **Nevada Budget Situation**

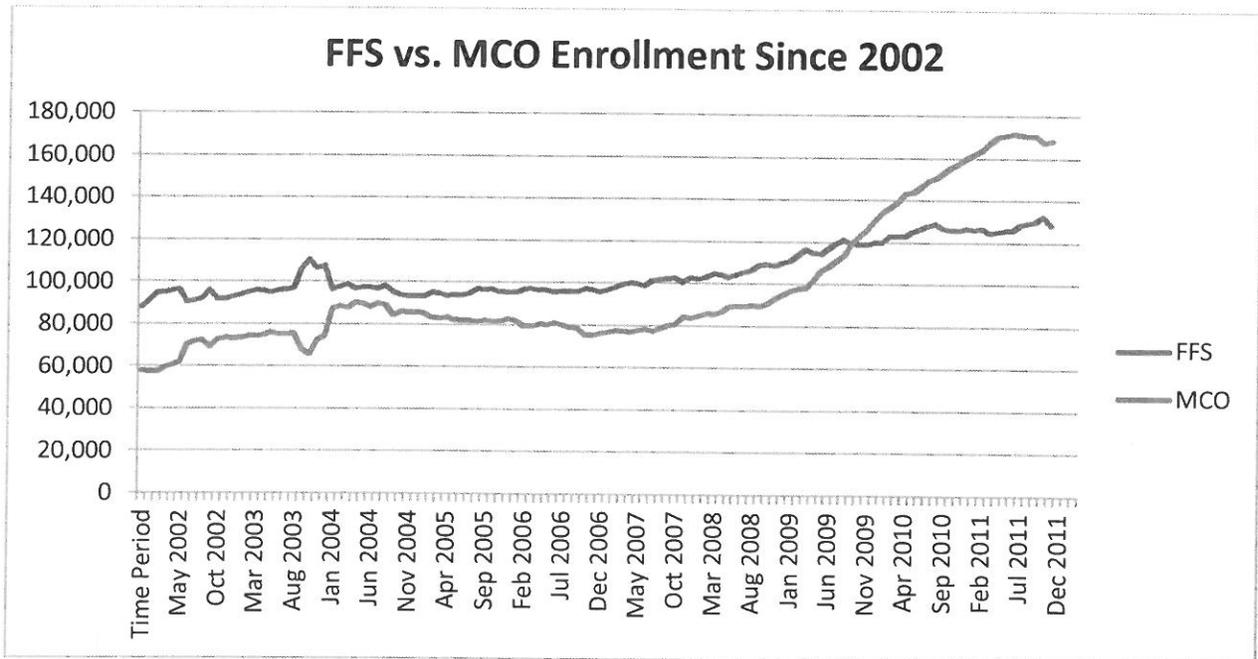
As Nevada prepares to head into the 2013 fiscal year, the state is still fighting to recover from the worst economic downturn since the Great Depression. Nevada has the highest unemployment rate in the country and is experiencing significantly depressed revenues, which has led to an increased demand for public services, including Medicaid.

Nevada is in the midst of a severe financial crisis. Nevada's Medicaid budget for the 2012 fiscal year totals \$1.6 billion, with over \$500 million coming from the State General Fund and other local funding. The budget continues to grow as more Nevadans become eligible for services. In August 2009 there were just over 230,000 recipients. By December 2011, the Medicaid caseload had grown to 303,814, an increase of just over 24% since December 2009. This rapid growth is reflected in the following chart:



### Use of Medicaid Managed Care

Nevada Medicaid has utilized Managed Care Organizations (MCOs) as a vehicle to improve quality of care and restrain the growth of health care costs. The traditional, risk-based managed care program is mandatory for certain recipients in urban Clark County and Washoe Counties. It is limited to Medicaid recipients who are eligible through Temporary Assistance for Needy Families (TANF) and the Child Health Assurance Program (CHAP) for pregnant women and children. This scope of capitated managed care, based on geography and eligibility categories, has meant that FFS arrangements are responsible for the highest need populations, and therefore, have the highest associated expenditures for the Nevada Medicaid program. The number of recipients enrolled in both FFS and MCO coverage over the past ten years is depicted in the table below:



The State has found that some form of “managed” health care improves health outcomes, produces cost savings and increases the ability to accurately forecast budgets. Unfortunately, existing financial drawbacks prevent the State from expanding the role of traditional risk-based managed care organizations to all recipients, statewide. First, the initial implementation of these expanded programs would result in paying capitation to an MCO while also paying incurred but not paid (IBNP) FFS service claims.

Milliman, Inc., an actuarial firm contracted with the DHCFP, analyzed this issue and determined that an expansion of this kind could involve millions of dollars over an approximately two year period. The savings of managed care might be realized, but this need to pay IBNP claims and capitation payments at the same time creates a “cash flow” situation that Nevada is not able to overcome. In addition to this ‘claims tail’ issue, the DHCFP cannot afford to lose the upper payment limit (UPL) funds that would take place. This would occur because the State would no longer be allowed to include inpatient hospital episodes for those newly enrolled managed care recipients.

#### **Essential Preparation for Medicaid Expansion**

Nevada plans to continue serving individuals currently receiving services under the Medicaid programs today. Nevada is not seeking Section 1115 Waiver authority to change eligibility for coverage under its Medicaid program or its 1915(c) waiver programs. It is essential, however, that Nevada begin to develop cost-effective care management programs that leverage a variety of service delivery and payment reform strategies. This is critical to prepare for the expansion of Medicaid coverage to newly eligible individuals in 2014 under the ACA.

The Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 was signed on March 30, 2010. These two pieces of legislation, collectively referred to as the Affordable Care Act (ACA) created healthcare reform with the goal of expanding health care coverage, controlling health care costs, and improving the health care delivery system. The Congressional Budget Office estimates the health reform law will provide coverage to an additional 32 million Americans when fully implemented in 2019 through a combination of Health Insurance Exchanges and Medicaid expansion. An initial analysis of the uninsured population in Nevada indicates that roughly one in five Nevadans currently do not have insurance. Many of these people could be newly eligible for Medicaid.

Federal health care reform will significantly expand Medicaid's role in Nevada. Residents under the age of 65 with Modified Adjusted Gross Income (MAGI) up to 138 percent of the federal poverty level (FPL) will be eligible for Medicaid. MAGI is a new standardized method for determining Medicaid income eligibility across the country. Income will be based on an Internal Revenue Service income tax definition, which is a change from the current methodology used by Medicaid. This significantly expands Nevada's current Medicaid eligibility criteria and income requirements, which is expected to lead to an influx of new recipients enrolling in Medicaid on or after 2014.

Enrollment in the State's Medicaid program has more than doubled over the past ten years, from roughly 105,900 recipients in June 2000 to 234,700 recipients in June 2010. This is before the changes go into effect in 2014. Nevada is among the states with the largest projected growth in its Medicaid program once the new MAGI requirements are implemented. According to a report by Public Consulting Group, Inc (PCG), approximately 600,000 non-elderly Nevadans, or 25.7% of the population, live in households with MAGI at or below 138% FPL. The Urban Institute estimates that the ACA eligibility expansion may increase Nevada's Medicaid rolls by 62% by 2019, compared to the estimated increase of 27% across the country. If such an increase in the number of enrollees occurs, Nevada's Medicaid program would likely experience one of the largest increases in enrollment among all states.

For the first three years of the expansion (i.e., 2014 – 2016), the federal government will cover 100% of the cost for those who are newly eligible. The federal share will decline to 95% in 2017, and by 2020, the State will need to pay for 10% of the cost for those Medicaid enrollees who become eligible due to the ACA's expansion of Medicaid eligibility. Even with much of the Medicaid expansion being directly funded by the federal government, the same analysis estimates that Nevada's share of Medicaid expenses will increase 2.9% (above normal medical inflation) compared to the 1.4% average increase across all other states. This is due to the fact that current eligibility for Nevada's Medicaid Nevada's program is fairly limited. For example, some states cover childless adults up to 100% FPL, which Nevada generally does not cover (with some exceptions, mainly related to the Aged, Blind and Disabled population). Therefore, when the expansion occurs, Nevada's enrollment will significantly increase. Newly eligible people in

Nevada's Medicaid program will constitute a larger percentage of the total Medicaid program than the US average.

### **Critical Need for Flexibility and Innovation**

The knowledge that this rapid increase in Medicaid enrollment will be occurring in 2014 created the catalyst for this NCCW request. The DHCFP is seeking Section 1115 waiver authority to implement a research and demonstration project designed to provide broad flexibility to manage the Medicaid program more efficiently.

Nevada needs to create innovative care management approaches aimed at tackling the unique circumstances within the state. One model recently identified is patient-centered medical homes (PCMH), which serves as an alternative model to improve quality of care and reduce costs. This model of care has been further bolstered by the inclusion of Section 2703 (the State Option to Provide Health Homes for Enrollees with Chronic Conditions) within the ACA. Nevada Medicaid has long been interested in a PCMH approach that would encompass delivery system transformations and rational payment reforms. A variety of system, program, and policy changes could be needed to implement such a model, which is why a measured, progressive approach is needed.

The State's exploration of Section 2703 with CMS identified significant barriers to attaining these desired reforms. For example, the State would like to allow a wide range of medical providers to serve as medical/health homes to better meet the varied needs of the target population. Some of these providers will only see a specific population (i.e. children with cardiac issues). In addition, some Medicaid recipients receive case management through a number of different Medicaid programs and do not need additional care management services. Therefore, Nevada needs to have the ability to include or exclude certain segments of the Medicaid population from the program. More flexibility is needed for Nevada to achieve the desired level of innovation within its Medicaid program. As the State prepares for the significant increase in Medicaid enrollment in 2014, it is imperative that Nevada begins to implement service delivery and payment reforms as quickly as possible.

When approved, the NCCW will allow the State to manage the care of those Medicaid recipients most in need of care management services. At this time, it will be outside of traditional managed care organizations and will remain budget neutral.

### **SERVICE DELIVERY REFORMS**

The NCCW will build upon the existing Nevada Medicaid delivery system to develop comprehensive care management programs. There will be three primary delivery systems under the NCCW: (1) Managed Care Organizations (MCOs), (2) a statewide FFS Care Management Organization (CMO), and (3) FFS Medicaid medical homes/health homes.

## **Managed Care Organizations**

Nevada's Medicaid program currently offers a traditional, risk-based managed care program operated through contracts with MCOs. DHCFP currently contracts with two MCOs, Health Plan of Nevada (HPN) and Amerigroup Community Care (AGP). DHCFP contracts with these MCOs to provide covered medically necessary services for eligible recipients at an established risk-based capitation rate.

DHCFP and the Division's external quality review organization (EQRO), Health Services Advisory Group (HSAG) closely monitor these two MCO's to assure that they continue to provide better health care outcomes, improved quality of life for recipients and monetary savings for taxpayers. An MCO must be in compliance with all applicable Nevada Revised Statutes, Nevada Administrative Code, the Code of Federal Regulations, the United States Code, and the Social Security Act. This assures program and operational compliance, as well as assuring that services provided to Medicaid MCO enrollees are done so with the same timeliness, quality, and scope as those provided to fee-for-service Medicaid recipients.

Nevada Medicaid requires mandatory enrollment in a MCO of some recipients found eligible in the urban areas of Clark and Washoe Counties. In order to ensure freedom of choice, enrollment in a managed care organization is mandatory for these recipients who live in an area where there is more than one managed care option to choose from. Recipients in these locations receive a letter shortly after eligibility is determined informing them of the choices. Failure to complete and return the letter within the specified timeframe will result in automatic assignment to one of the HMOs.

### **MCO Procurement History**

Managed care and care coordination are both methods of payment and care delivery models. The objectives of Nevada's MCO program are to improve access to services and increase coordination of care, while controlling the cost of services. The MCO contracts are paid a risk based capitated rate for each eligible, enrolled Medicaid recipient on a per-member, per-month (PMPM) basis. These capitated rates are certified by an actuary. A formula for stop loss is also used when costs of care exceed a threshold during a specified time period.

After experimenting with a PCCM style of service delivery in the 1990s, the Nevada Medicaid program began contracting with MCOs for mandatory managed care in the urban areas of Clark and Washoe Counties. A reprocurement for the MCOs was conducted in 2006, with Health Plan of Nevada continuing as a vendor and Anthem Blue Cross/Blue Shield Partnership Plan joining the program as a new vendor.

In 2008, after being denied a large rate increase, Anthem Blue Cross/Blue Shield Partnership Plan terminated its contract with the State of Nevada. Permission was sought from the State's Purchasing Division to turn to the next highest Vendor in the 2006 procurement rather than rebid

the contract. On February 1, 2009, AGP joined the Nevada Medicaid program as a managed care vendor.

At the time AGP joined the program, the DHCFP decided to immediately extend the contract through June 30, 2012. In 2011, the contract was extended for another year to give the State time to determine the impact of the Medicaid expansion population and essential benefit package stemming from the ACA, on the MCO re-procurement.

### **Current SPA Authority (Covered Population)**

As previously discussed, the State of Nevada operates both a fee-for-service (FFS) and a managed care system to provide services to its Medicaid eligible population. The DHCFP oversees the administration of all Medicaid MCOs in the state. Recipients in the managed care programs are enrolled on a mandatory basis under authority granted under section 1932 (a)(1)(A) of the Social Security Act. This authority allows Medicaid to amend its State Plan to require certain categories of Medicaid recipients to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness, freedom of choice or comparability.

Enrollment in an MCO is mandatory for TANF (Section 1931) and CHAP (poverty level pregnant women, infants, and children) recipients in urban Washoe and Clark Counties. There are currently two MCOs from which they may choose. Mandatory enrollment includes recipients who are eligible for Medicaid program coverage under the following Medicaid eligibility categories:

- a. Temporary Assistance for Needy Families (TANF);
- b. Two parent TANF;
- c. TANF – Related Medical Only;
- d. TANF – Post Medical (pursuant to Section 1925 of the Social Security Act (the Act));
- e. TANF – Transitional Medical (under Section 1925 of the Act);
- f. TANF Related (Sneede vs. Kizer);
- g. Child Health Assurance Program (CHAP); and
- h. Aged Out Foster Care (young adults who have “aged out” of foster care).

Certain groups of recipients are excluded from the requirement of mandatory managed care:

- a. Recipients who are also eligible for Medicare
- b. Native American Indians who are members of Federally recognized tribes

- c. Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI)
- d. Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
- e. Children under the age of 19 years who are in foster care or other out-of-home placement.
- f. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
- g. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V and is defined by the state in terms of either program participation or special health care needs.

Nevada Medicaid also allows certain groups of Medicaid recipients that are exempt from mandatory enrollment to voluntarily enroll in an MCO, if they so choose:

1. TANF and CHAP adults diagnosed with a serious mental illness (SMI)
2. TANF and CHAP Children diagnosed with a severe emotional disturbance (SED)
3. TANF and CHAP Children diagnosed as Child(ren) with Special Health Care Needs (CSHCN)

**Proposed Changes to MCO Enrollment**

Nevada is seeking to make a number of changes related to managed care enrollment under the NCCW. To be clear, the State is not currently seeking authority to change eligibility categories subject to mandatory MCO enrollment. However, Nevada may request this change in Phase Two if it is determined that it would best meet the needs of the program.

Nevada is requesting the authorization, but not the immediate obligation, to require new TANF and CHAP recipients to choose a Medicaid MCO as part of their eligibility application or be auto-assigned immediately upon approval of Medicaid eligibility. Recipients would be allowed a 90-day period to change MCOs without cause. After the 90-day period, only plan changes for cause will be allowed; however, changing MCOs will be possible thereafter once a year during an open enrollment period. Every recipient will have the opportunity to change MCOs at least once every twelve months.

In the current environment, recipients who temporarily lose eligibility but return within 60 calendar days are automatically re-assigned to their prior MCO. Those recipients who return after 60 days are given a 30 day choice period during which they may select enrollment in either MCO. Under the NCCW, Nevada is seeking to modify this so that all returning Medicaid

recipients are auto-assigned to their prior MCO, regardless of the length of the break in eligibility, as long as that MCO is still contracted with the State.

As with the rights afforded to recipients who return within 60 days, these returning recipients who have been ineligible for 61 days would not have the 90 day right to change MCOs without cause that is offered to first-time managed care enrollees. They would retain the right to change with cause at any time, and they would have the annual open enrollment opportunity to switch plans. Automatically re-assigning returning members to their prior MCO after the 60<sup>th</sup> day will solve an ongoing problem of unmanaged periods of time in the FFS system. This time in FFS prevents recipients and family members from utilizing the care coordination benefits provided by the MCO under the managed care program. It is also more expensive to the State.

An example is a family that loses eligibility for non-cooperation at the end of September. They re-apply on December 5 and are approved on January 18. Under the current regulations, this family would be FFS until their 30-day choice period ended on Saturday, February 18, the President's Day holiday weekend would result in an auto assignment to an MCO taking place on February 21. This would be past the administrative cutoff date for a March enrollment, so they would remain in FFS until April 1. Under the requested NCCW, this family would be assigned on their approval date (January 18), effective February 1. This would return the family to their MCO in February instead of April, providing State savings and recipient managed care privileges a full two months earlier. This auto assignment would only be applied if the recipient did not otherwise select an MCO at the time of application.

### **Alternative Managed Care Delivery Systems**

While the MCO enrollment changes referenced above would improve the continuity of care for some Medicaid recipients, existing managed care plans do not serve many of the current highest need populations and for whom the benefits of care coordination could be the greatest. At this time, Nevada Medicaid does not contract with other organized delivery systems such as PCCMs, Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs). Contracted MCOs are currently the only managed care entities providing Medicaid managed care in Nevada. Under the NCCW, Nevada will phase in all other "managed care" options through a variety of accountable care coordination entities in which recipients can enroll. The thrust of the NCCW is to create a "managed" FFS environment through the implementation of various care management programs, ultimately integrating primary medical, acute medical, long-term care and behavioral health services.

### **Previous Care Management Efforts**

A PCCM model was operated by DHCFP in the 1980s and 1990s. The program was a voluntary program open to select recipients who fell under either the Aged or the Aid to Dependent Children (ADC) categories in Washoe or Clark Counties. It began with the University of

Nevada, Reno and University of Nevada, Las Vegas Schools of Medicine before expanding to include other community organizations like NevadaCare and Community Health Centers of Southern Nevada. In addition to the standard FFS system, a PMPM payment was paid to PCPs to perform case management services. The program ended when the DHCFP implemented the risk based capitated managed care program.

Over recent years, the cost of providing care for Aged, Blind, and Disabled (ABD) recipients through Nevada's fee-for-service system has risen at a significantly higher rate than the rate of the TANF/CHAP population. The ABD population is one with complex medical and social needs complicated by chronic diseases and multiple co-morbidities. In addition, this population has a high rate of behavioral health diagnoses and a risk of non-compliance with medications.

Subsequently, the 2007 Nevada Legislature appropriated funding to DHCFP to improve quality of care in a cost effective manner for the Nevada Medicaid FFS population. Specifically, DHCFP began exploring opportunities to improve the health of recipients who have frequent emergency room and hospital utilization. In addition, there was great concern about the lack of care coordination for children under the age of 21 who were utilizing behavioral health services in a residential or inpatient setting. These children were generally involved in multiple systems of care that was resulting in service duplication, unnecessarily long length of stays in Residential Treatment Centers (RTCs), and an overall lack of coordination.

Based on the direction of the Legislature, the DHCFP issued a RFP in 2007 for a Disease Management (DM) vendor. DM is a system of coordinated health care interventions for people with chronic conditions or diagnoses aimed at improving their health outcomes and reducing avoidable ER and hospital utilization. In addition, the RFP requested care coordination for children in RTC's. In 2008, a vendor was awarded the two-year contract to provide care management, care coordination, and behavioral health provider recruitment. The vendor began accepting recipients for the programs in July, 2008.

As the contract progressed, it became apparent that while an outside vendor can assist with care coordination activities, primary care providers (PCPs) need to be the focal point of managing care and reducing unnecessary hospitalizations. In addition, Disease Management (DM) and Care Management Organizations (CMOs) must move beyond a strictly phone contact and disease management approach. They must also have a system that tiers the case management response needed based on recipient needs. Specifically, DM and CMOs must provide in-person services to some recipients and physicians.

DHCFP also asked our contracted EQRO to perform a compliance review assessing the DM vendor's adherence with contractual requirements. The audit exposed important insufficiencies with some of the vendor's programs and its compliance with DHCFP contractual requirements, especially related to continuity of care and case management. Subsequently, DHCFP required the

vendor to submit a corrective action plan intended to ensure that the structure and operation of its programs adhered to the contract standards.

This compliance audit noted a lack of completed baseline assessments for its enrollees. Effective case management activities require coordinators to work with the PCPs and family members, as well as complete individualized treatment plans to identify the needs of recipients, which was not being done. The vendor had not documented referrals to and/or coordination with other agencies or programs to ensure that the recipients' needs were being met. Moreover, the EQRO identified that staffing levels were inadequate for the contracted services to be performed.

DHCFP also asked the EQRO to evaluate the vendor's performance measures using Healthcare Effectiveness Data and Information Set (HEDIS) measures. The purpose of this report was to determine if enrollees in the program had specific improved health outcomes as a result of receiving the care coordination. Results determined that none of the measures met the goal of demonstrating improvement.

Although DHCFP did not renew the contract, DHCFP believes a care management program that includes the proper components can improve the health of Nevada's high need Medicaid FFS recipients. DHCFP has incorporated the lessons learned from the DM program, as well as information obtained from various entities, such as other states, CMS, SAMHSA and HRSA, into the proposed new CMO program. Conducting baseline assessments, in-person when needed, and integrating the medical, behavioral and social issues with every enrollee must occur to provide adequate care management. The provider and case manager need to work as a team to form an action plan. It is impossible to know if interventions are successful without a place to start from.

Developing a detailed plan to engage physicians and other medical providers on an initial and ongoing basis in a care management program is also critical. Medical providers were not incentivized to work with the DM vendor. They did not receive any benefit from the program, other than hopefully improved health outcomes for their patients. Since providers are delivering the care, they need to receive some sort of incentive to take the time to work with an outside vendor. Moreover, providers will only be interested in a care management program if a significant number of their patients are eligible for the program. They do not have the time or resources to participate for a handful of patients. The providers also need an easy way to identify the patients if only some of their patients participate. Overall, it needs to be a simple and straightforward program.

Another major challenge was that the DM program was a voluntary, opt-in program for recipients. This contributed to the slow start-up of the program. It is expected that automatic enrollment in a care management program could have led to more success.

## Exploration of PCMH Approaches

The State of Nevada has joined a nationwide movement in exploring other options to serve high-cost Medicaid populations. The DHCFP consulted with a variety of national and state resources, in addition to participating in collaborations like the Patient-Centered Primary Care Collaborative and the Washoe County Juvenile Justice medical homes project. On the national level, the DHCFP conducted a literature review of related research publications and obtained feedback from the CMS, DHCFP vendors, and other state medical home programs, including Indiana, Oklahoma, and Colorado. The Nevada DHHS sent a team of State subject matter experts to the Coordinated Care meeting hosted by SAMHSA, HRSA, and CMS in Seattle in August, 2011. DHCFP also sought input from Nevada stakeholders, including Federally Qualified Health Centers (FQHCs), the State Health Division and the Nevada Health Care Coalition. DHCFP began focusing on several major approaches to coordinating the care of high cost populations:

- **Patient Centered Medical Home (PCMH)** – This model builds upon the original Primary Care Case Management concept and was most recently defined in the Joint Principles for Patient Centered Medical Home. A physician, or in some states, a nurse practitioner, is responsible for coordinating most aspects of a patient’s care and receives additional compensation for doing so. The benefit to this model is that physicians already have the medical skills, expertise, and patient relationships needed to coordinate care. Potential challenges include a provider’s lack of time and resources to coordinate care and limited knowledge about community resources.
- **Administrative Services or Care Management Organization (ASO/CMO)** – In this model, the State contracts with an outside vendor to perform care management services. The benefit to this model is that ASOs (or CMOs) generally have vast experience in providing successful care management services. Potential challenges include maintaining communication and collaboration with the providers who are actually developing the treatment plans and providing care.
- **Networks and/or Accountable Care Organizations (ACO)** – Networks and ACOs are similar concepts. Networks are primarily being used in North Carolina, although other states like Colorado and Louisiana have developed similar programs. As a relatively new model that is employed by only a few local communities, ACOs contain elements from PCCM, managed care, and ASO/CMO models. The ACO model includes hospitals, primary care providers, specialists, and other medical professionals who provide the vast majority of care within their respective networks and are held accountable for patient care and outcomes. They also share PMPM and/or performance-related payments. The benefit of this model is that it would encompass a wide range of health care providers, potentially having the most effect on health outcomes and expenditures. A potential challenge includes identifying enough providers who would be interested in participating in local

networks. Moreover, the newness of this model means that more time is needed to gauge success.

On February 11, 2010, DHCFP issued a Request for Information (RFI) on the PCMH model. Given the complexities of these types of programs and the number of partners that could be involved, DHCFP solicited information on all options. The Division of Health Care Financing and Policy issued the RFI specifically to:

1. Gather input, suggestions, and feedback on how Nevada Medicaid could implement a cost effective medical home and care coordination program, specifically for high needs, high-cost patients;
2. Gauge stakeholder interest in participating in a medical homes program; and,
3. Receive feedback that could be used to develop a RFP.

In March of 2011, a DHCFP contracted vendor, Public Consulting Group, Inc (PCG), completed a readiness assessment to determine the feasibility of implementing a medical home initiative in the existing Nevada environment. The analysis of FFS utilization and spending metrics pointed to the need for some sort of care management approach for this population. For a few select provider groups who had shown an interest and taken action toward becoming certified as medical home providers, there appeared to be opportunities that existed with this model. A scorecard that evaluates the “readiness” of the provider community and DHCFP to implement a successful patient-centered medical home was developed. The scorecard utilized a scale of 1 (not ready) to 5 (ready or operational) for each criterion. PCG provided a score based on the assessment of the current situation and what may be possible over the next two to three years. The results of PCG’s assessment are summarized below:

***Nevada Provider Medical Home Readiness Review***

Area	Current	In 2 – 3 years
Meeting credentialing standards (such as NCQA)	<b>Score: 1</b> Only four providers (all a part of the Renown system) statewide currently meet NCQA Level 1 standards. RFI results indicated that it would be difficult for most providers to achieve even Level 1 status. As of the date of this report, one provider has achieved Level 1 status and others – including Southwest Medical Associates – are working toward this certification goal.	<b>Score: 3</b> Limited interest expressed except for a few provider groups. Prompting by payers (e.g., Medicaid, Culinary Fund) could provide momentum for obtaining accreditation.

Practice culture and Structure

**Score: 2**

Requires acceptance of new technologies, changes in how care is delivered, and use of multi-disciplinary teams. With a few exceptions, the provider community appears to be slow in the change that would be required. RFI indicated limited knowledge about medical homes.

**Score: 3**

Relatively few champions to drive these changes exist. Opportunity may reside in a few leaders with successful pilots.

Practice size and scope

**Score: 2**

Nevada does have large multi-specialty practices and integrated health delivery systems that can be leveraged, but there are only a few. Fragmented delivery system.

**Score: 4-5**

The infrastructure challenge can be addressed by using third party vendors to provide administrative/"back office" infrastructure for smaller providers.

Technology infrastructure

**Score: 2-3**

Limited use of EMRs with the exception of a few practices and integrated delivery systems (these receive a 3). RFI responses identified costs as a key barrier.

**Score: 4**

With the proper leadership from the medical and payer community, implementation of healthcare technologies is possible, especially leveraging access to federal funding available in American Recovery and Reinvestment Act (ARRA). Nevada's preliminary EHR incentive payment program estimates more than 450 providers will be meaningfully using EHR by 2014.

Experience

**Score: 1**

No true health homes exist today. Other payers do not appear to be interested. At least one large integrated health delivery system is interested in pursuing health homes certification.

**Score: 5**

Pilots can drive key learnings and opportunities.

Financials

**Score: 2**

Cuts in Medicaid reimbursement will strain relationship between providers and the State. Limited experience with pay-for-performance. Providers perceive high cost to develop their practice into a medical home as a key factor.

**Score: 4-5**

Properly structured pay-for-performance and federal government subsidies could lead to greater adoption of health homes.

From the results of this assessment, DHCFP determined that opportunities for a broad-based Medicaid medical homes program in Nevada would be challenging. Aside from select providers, the assessment, which consisted of conversations with key stakeholders and review of the medical home RFI responses, revealed limited interest by provider groups. PCG did not believe that Nevada would be able to successfully implement Medicaid medical homes statewide, although, opportunities did exist for pilot programs. Assuming that pilots pursued are successful, an opportunity exists to expand the Medicaid medical homes concept. Under the NCCW, significant progress over the next two to three years can be achieved in establishing the “managed” FFS structure required for alternative care management approaches, especially as it relates to pay-for-performance and implementing the necessary HIT infrastructure.

This exploration around implementing a PCMH initiative has led the DHCFP to take a dual-pronged approach - a hybrid between implementing Medicaid medical homes and establishing a care management program. A CMO will be hired to enhance care coordination while Medicaid medical homes are established. The limited number of large multi-specialty practices and integrated health delivery systems potentially limits the capacity of provider organizations to meet the defined requirements (either national recognition such as National Committee for Quality Assurance (NCQA) or Health Home standards under Section 2703 of the ACA) on a statewide basis. However, there are medical professionals who can provide the type and level of services commensurate with a Medicaid medical home, and so implementation of Medicaid medical home pilots could begin.

Since the readiness review was initially completed, there are now three NCQA Level III medical practices based at numerous locations in Reno/Sparks and Las Vegas/Henderson, and one Level II practice in Carson City. At the same time, DHCFP will use the CMO to achieve quality improvement and savings, while they also begin to provide a medical home “infrastructure” to be utilized by providers who do not have resources to build a Medicaid medical home. Although there has been significant progress in the development of NCQA recognized medical homes in the state, the DHCFP believes the dual-prong approach is needed to achieve maximum outcome and savings potential.

### **Care Management Organization**

Under the NCCW, Nevada will implement a comprehensive care management program. A CMO will be procured to manage high-cost, high need Medicaid FFS enrollees. The scope of contracted services would be two-fold. First, quality of care and health outcomes will be improved as a result of assisting the recipient to receive the correct level of care at the correct time. This improved care coordination is expected to provide a degree of cost savings for the current Medicaid FFS population. Second, a cost-effective, statewide infrastructure will be developed to promote the further expansion of Medicaid medical homes/health homes.

## **Care Management Organization Scope of Services**

The CMO program will include the components of care management listed in Section 2703 of the ACA, including: comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up from inpatient to other settings; patient and family support; referral to community and social support services, if relevant; and use of health information technology to link services, as feasible and appropriate. Unlike the administrative approach employed by the DHCFP for its previous DM program, care management through the CMO will be a direct service, for example, assessing a recipient's health status, coordinating with a patient's care team, developing a care plan with the recipient, teaching self-management, and facilitating access to appropriate care.

Care management will go beyond telephonic care management to regularly contacting patients, monitoring patient status, delivering patient education and counseling, providing appointment reminders, and facilitating referrals for coping with illness. Care management will include in-person visits to provide care management interventions. Evidence indicates that in-person care management is the most effective intervention across all diseases, and is most likely to impact clinical outcomes, utilization, and cost.

The CMO will also provide the infrastructure necessary to enable small physician practices to function as Medicaid medical homes and health homes.

## **Care Management Target Population**

The CMO will include the Medicaid eligibility categories of Aged, Blind and Disabled (ABD), Temporary Assistance for Needy Families (TANF) and Child Health Assurance Program (CHAP) assistance groups. This population served by the CMO will encompass Medicaid recipients who have at least one chronic condition and/or a serious and persistent mental health condition as defined by the following criteria based on the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM):

- Asthma: ICD-9-CM codes 493-493.93;
- Chronic Bronchitis/Emphysema: ICD-9-CM codes 491-492.8;
- Diabetes Mellitus: ICD-9-CM codes 250-250.93;
- End Stage Renal Disease: ICD-9-CM codes 584-586;
- Heart Disease: ICD-9-CM codes 390-459;
- Neoplasm: ICD-9-CM codes 140-239;

- Obesity: ICD-9-CM codes 278-278.8;
- Mental Health: ICD-9-CM codes 290-290.9; 293-298.9; 300-302.9; 306-316;
- Substance Abuse: ICD-9-CM codes 291.0-292.9; 303.00-305.93; and
- HIV/AIDS: ICD-9-CM codes 042, 079.53 with diagnosis code V08.

High-risk pregnancies will also be part of the program in order to improve birth outcomes and reduce costs. Additional conditions and utilization patterns may also be added if the DHCFP feels care management would benefit the enrollee.

### **Care Management Enrollment**

The DHCFP will identify Medicaid recipients who meet the criteria for enrollment in the CMO on a monthly basis. Medicaid recipients who meet the targeted conditions above will be mandatorily enrolled in the program. The DHCFP will assign the recipient to the CMO and will provide the CMO with a monthly membership file of eligible recipients.

A recipient who is enrolled in the care management program through the CMO on a mandatory basis may request disenrollment from the CMO to enroll with a qualified Medicaid medical home/health home. The Enrollee is required to notify the DHCFP of his/her decision to disenroll and, as a mandatory recipient, will be instructed to select a Medicaid medical home/health home provider, if one is available. If a medical/health home is not available, they must stay enrolled in the CMO.

### **Care Management Payment Mechanisms**

Rather than paying a health insurance entity an insurance premium to provide comprehensive medical services, the State would contract with the CMO to provide care management as a Medicaid service. The CMO would be paid a PMPM service rate to provide care management services to targeted populations. For each Medicaid recipient enrolled in the CMO, the DHCFP will make a prepaid, per-recipient, per-month payment as payment in full for any and all covered care management services provided to the recipient. This approach would also include alternative payment arrangements, such as pay-for-performance and shared savings mechanisms to align incentives for effective care coordination.

In developing the proposed payment arrangements, DHCFP focused on three key considerations:

- Quality of Care – The methodology needs to ensure that the CMO is incentivized to improve the quality of medical care received by program participants.
- Cost Reduction – The payment methodology needs to include incentives for the CMO to reduce medical costs.

- Simplicity – The methodology needs to be easily understood by all parties and not subject to varied interpretations.

In addition to the fixed PMPM that will be paid to the CMO, an annual incentive payment may be made based on a combination of cost savings and quality of care. The value of this payment will be calculated as follows:

$$Bonus = Savings \times [ 66\% - 1.2 \times (100\% - Overall\ Quality\ Score) ]$$

Note that, under this formula, the maximum bonus is equal to 66% of total savings. In addition, no bonus will be paid if the overall quality score is less than 45%.

The various components of the formula are built up as follows:

#### *Savings*

The value of “Savings” in the formula above will be defined as the difference in risk-adjusted medical costs for the eligible population between the contract period and the baseline period. To calculate these savings, the following calculations would be performed for both the baseline and performance periods:

- Identify the eligible population based on the contractually defined criteria,
- Determine the total member months for the eligible population,
- Calculate a risk score for the eligible population, using the Chronic Illness and Disability Payment System (CDPS), version 5.3,
- Sum the medical cost for all eligible individuals, including only the months of the period during which each individual was a member of the eligible population, and
- Total the fixed PMPM costs paid to the CMO for program management

Using these calculations, total cost savings would then be calculated as

$$Savings = \left( Claims_{BP} \times \frac{Risk\ Score_{CP}}{Risk\ Score_{BP}} \times \frac{Member\ Months_{CP}}{Member\ Months_{BP}} \right) - Claims_{CP} - Fixed\ Costs_{CP}$$

In this formula, a “BP” subscript indicates measurements for the baseline period. Similarly, a “CP” subscript indicates measurements for the performance period.

#### *Condition Specific Quality Scores (used to develop the Overall Quality Score)*

The DHCFP has developed a list, by condition, of the quality measures that will be used in the calculation of the condition scores. The quality improvement target for each quality measure will be equal to 10% of the difference between 100% and the value of the measurement during the baseline period for the eligible population.

For example, if the value of a given quality measure during the baseline period was 60%, the CMO would be expected to increase the measure by 4%, to 64%. This is calculated as 4% = 10% x (100% - 60%). Each measure that shows improvement equal to or greater than the targeted improvement is considered “achieved”.

For each condition, the Condition Specific Quality Score would be calculated as the number of “achieved” targets divided by the total number of quality measures for that condition. As an example, if a particular condition has 4 quality measures, and the CMO achieved the required target for 3 of those measures, the condition score would be 0.75, or 75%.

### *Overall Quality Score*

The value of “Overall Quality Score” included in the formula above will be calculated as a weighted average of Condition Specific Quality Scores (described below). The weights used for each Condition Specific Quality Score would be the proportion of individuals in the eligible population with that condition. The proportion would be calculated using member months, not unique individuals.

As an example, assume the following:

- Condition 1 score: 75%
- Condition 2 score: 100%
- Condition 3 score: 50%
- Prevalence of condition 1 in the eligible population (member months basis): 50%
- Prevalence of condition 2 in the eligible population (member months basis): 40%
- Prevalence of condition 3 in the eligible population (member months basis): 30%

Under this scenario, Overall Quality Score would equal:

$$\frac{75\% \times 50\% + 100\% \times 40\% + 50\% \times 30\%}{50\% + 40\% + 30\%} = 77.1\%$$

Note that the total of all prevalence amounts is greater than 100%. This is to be expected, as many individuals in the eligible population will have more than one condition.

### **Care Management Procurement and Implementation Process**

A Request for Proposals (RFP #1958) for CMO services was released on February 1, 2012. DHCFP intends to contract with a highly qualified and experienced provider, which will administer a new type of care management services to assist DHCFP in reaching its goal to expand enrollment of the targeted populations into a managed FFS system. The target population for this managed FFS system comprises Medicaid recipients with chronic conditions. The ensuing infrastructure will be crucial to moving Medicaid medical homes into more

comprehensive Medicaid health homes and increase the availability of integrated, holistic physical and behavioral care, as well as long-term supports and services.

Because the value of the RFP is anticipated to be over \$100,000, the Nevada Revised Statutes and the Nevada Administrative Code require the Nevada Purchasing Division to facilitate the bid process. The RFP responses are due to, and will be opened by, the Purchasing Division on April 24, 2012. An evaluation committee will meet on to pick the top four Vendors from the bids. The top four Vendors will be invited to Carson City for presentations on May 22 and 23, 2012. The contract will be awarded on May 24<sup>th</sup>.

The contract is anticipated to be effective from September 1, 2012, subject to Board of Examiners approval, to July 31, 2014, with one (1) optional renewal period of two (2) years. Renewal shall be by mutual agreement and by written amendment to the contract. Any contract extension will be contingent upon a re-examination of the payment methodology, possibly including tiers. Prior to expiration of the original contract period, or any renewal period thereafter, DHCFP reserves the sole right not to exercise the option to renew for any or all of the renewal periods.

Because the contract will not be final until the August 14<sup>th</sup> Board of Examiners Meeting, with an expected contract effective date of August 15<sup>th</sup>, actual coordination of recipient care might not begin until October 1<sup>st</sup>. This will give the winning provider time to open offices in the State, hire and train staff, and begin to contact providers. A readiness review is scheduled for the third week in September.

Authorization to operate as a CMO in the State of Nevada with the projected number of Medicaid recipients is subject to the approval of this Section 1115 Research and Demonstration Project Waiver by the United States Secretary of Health and Human Services. This approval is the critical first step in a multi-phased approach to expand managed care strategies to Medicaid populations through a variety of service delivery and payment reforms.

### **Medicaid Medical Homes & Health Homes**

Leveraging the infrastructure created through the establishment of the CMO, Nevada will implement a Medicaid health homes and medical homes program for non-MCO enrollees, including those with chronic conditions, severe mental health issues or patterns of utilization that indicate the enrollee may benefit from care management. Health homes are defined under Section 2703 of the ACA. This comprehensive care coordination includes integration of behavioral health services and linkage with long-term supports and services, as well as enhanced use of health information technology (HIT).

Conversely, Nevada's approach to the NCCW also allows for the creation of broader-based Medicaid medical homes. The DHCFP's Medicaid medical homes will use many of the principles of the original PCCM concepts and defined Joint Principles for the PCMHs (from the

American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA)). However, flexibility is important in addressing the diverse needs of the Medicaid population, which is why Nevada's Medicaid medical homes will not need to meet all of the requirements of a health home or the Joint Principles. Instead, the DHCFP will allow providers to apply for Medicaid medical home status based on a list of DHCFP established criteria and qualifications. Although Medicaid medical homes could have a broader definition than Medicaid health homes, all of these providers will need to clearly identify their methods for better managing their patients' care and improving health outcomes.

### **Development of Medicaid Medical Homes and Health Homes**

DHCFP will use the NCCW to implement a care management program to manage high-cost, high need patients and those with chronic medical conditions. This "managed" FFS system will integrate the medical, behavioral health and long-term care needs of the Medicaid recipients. Medical/health outcomes should be improved and cost savings should be achieved as a result of these care coordination activities. Additionally, DHCFP will leverage the CMO to develop a cost-effective, infrastructure to help small medical practices meet Medicaid medical home and/or health home requirements, thereby promoting the expansion of alternative "managed care" programs for the Medicaid FFS population in Nevada. As part of its overall care management program, the DHCFP will develop Medicaid medical homes and health homes. Health care providers will receive assistance from the CMO to become qualified medical/health homes.

Nevada's Medicaid medical homes will provide accessible, continuous, coordinated and comprehensive health care partnerships between individual members (and when appropriate, their family) and their personal providers. This person-centered approach will focus on the person who has a disease or illness, and how the disease or illness impacts their life, rather than on the illness or disease itself. If implemented successfully, this approach will result in better informed recipients who are better able to participate in their care, ultimately leading to better clinical outcomes. Medicaid medical homes will also improve access to health care, increase satisfaction with care, and improve health.

On the other hand, Medicaid health homes will be medical home providers who meet higher standards for care coordination. They also function as comprehensive care management providers across behavioral and long-term care systems.

These Medicaid medical home and health home pilot projects will be established by the DHCFP under the NCCW. Medicaid medical homes and health homes will be chosen by the DHCFP through a selection process, using criteria established by the DHCFP to meet the varied needs of the targeted population. It is expected that the CMO will provide assistance to smaller physician practices in the form of data analytics, risk stratification, care gap identification, care coordination infrastructure and other supports that enable the emergence and ongoing operations

of Medicaid medical homes and health homes [and potentially other service delivery innovations] established by the DHCFP. The level and type of services the CMO provides to the Medicaid medical home or health home will depend on the needs of the individual provider. Supports to assist practices seeking enrollment as a Medicaid medical home and/or health home provider could include:

- Providing the central team framework for coordinated care across different medical providers and integrating clinical and non-clinical health care related needs and services. The CMO will ensure data is shared and person-centered plans are updated when goals are achieved or care needs change.
- Providing quality-driven, cost-effective, culturally appropriate, and person and family-centered health home services;
- Coordinating and providing access to high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordinating and providing access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordinating and providing access to mental health and substance abuse services;
- Coordinating and providing access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- Coordinating and providing access to chronic disease management, including self-management support to individuals and their families;
- Coordinating and providing access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinating and providing access to long-term care supports and services;
- Using health information technology to link services, facilitate communication among team members and with the individual and family caregivers, and providing feedback to practices, as feasible and appropriate; and
- Establishing a continuous quality improvement program, and collecting and reporting on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

The CMO's assistance will provide certain health care providers with the supports they need to obtain the DHCFP's approval to function as qualified Medicaid medical homes or health homes.

### **Contracting Process for Medicaid Medical Homes and Health Homes**

The NCCW will permit Nevada to implement value-based purchasing that allows for flexibility in contract requirements for Medicaid medical homes/health homes with respect to covered populations, scope of services, and payment reforms. Under a phased approach to broader care management through managed FFS arrangements, DHCFP would contract with health professionals to provide Medicaid medical homes or health homes to populations with high costs and extensive needs.

Nevada will institute payment reforms that establish single points of accountability for identified recipients and provide incentives to efficiently integrate services that meet the complex needs of recipients with chronic conditions. Specifically, Nevada will seek to obtain authority to contract with eligible entities using alternatives to traditional FFS payment arrangements, such as capitation, partial capitation, shared savings, bundled payments, global budgeting and/or other types of payment reforms.

Medicaid medical homes and health homes can be funded through a wide range of payment methods. On one end of the continuum, qualified providers receive a care management fee plus regular FFS reimbursement. That is, all medical services are reimbursed on a fee-for-service basis. Accountable Care Organizations (ACO) are on the other end of the continuum, where an organized group of medical professionals provide full integration of services. These multiple services providers receive risk-based capitation and pay-for-performance payments. Nevada is looking at developing an enhanced FFS payment for its Medicaid medical/health home practices, in addition to a PMPM care management fee. The program will also initiate a pay-for-performance program that would provide additional payments to Medicaid medical homes and health homes for meeting defined quality metrics. This would be similar to the shared savings approach for the CMO previously described. Nevada would like to explore all of the options along this continuum.

The DHCFP may also capitate Medicaid medical homes and health homes for the full range of preventive and primary health care services. This approach is called partially capitated reimbursement because only preventive and primary health care services are capitated. Other covered services, such as inpatient and outpatient hospital care and specialty physician services remain under the FFS payment system. In these arrangements, Medicaid medical homes and health homes not only provide primary care, preventive care, and care management services to each assigned recipient, but they also refer the patient to other medical professionals, as medically necessary and appropriate, and are responsible for monitoring and coordinating all such care.

Medicaid medical homes may be fully capitated to cover other Medicaid services depending on the capabilities of the specific practice or the larger organized health care delivery systems in which they operate. These might include specialty physician services (in a multi-specialty practice, for example) and/or inpatient and outpatient hospital services (in an integrated delivery system, for example). This would result in paying hospitals or physician practices a global fee to reimburse for all care provided to recipients assigned to the accountable, contracted provider.

As an alternative to full capitation, DHCFP may implement bundled payments for select procedures. Bundling payment for services that recipients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. Ideally, all payment reforms would provide bonuses for high performance on certain quality measures. However, pay-for-performance mechanisms would need to be tailored to the specific scope of care and financing associated with each Medicaid medical/health home.

The potential variations in individual contracts for Medicaid medical homes and health homes are nearly limitless, which is why the State needs the ability to construct contract payments with Medicaid medical homes and health homes that are in the best interests of the State, providers and eligible recipients. Operational flexibility is needed to enable Nevada Medicaid to quickly respond to changing health care market needs.

The State of Nevada is seeking broad authority to contract with eligible entities for an appropriate array of covered services without the cumbersome delays of policy-specific negotiation, obtaining specific waiver authority (via waiver amendments) and CMS contract reviews each time a scope of covered benefits or alternative payment arrangement is developed with these entities. Contracts with these entities, which could be classified as Prepaid Inpatient Health Plans (PIHPs) or Prepaid Ambulatory Health Plans (PAHPs), would not require CMS approval under the NCCW. Waivers of managed care rate setting rules would also be granted. MCO rates must be actuarially certified and are predicated on historical costs. This leads to a “cost-plus” approach to setting rates. Instead, rates need to consider trend factors associated with the best management practices in Medicaid managed care. This new state-federal compact will provide greater operational flexibility to the State in exchange for budgetary certainty for the Federal government.

## **COVERED SERVICES**

### **Current Medicaid Services**

The services available under the NCCW would include current mandatory and optional State Plan services, as described below.

### **Mandatory Medicaid State Plan Services**

Title XIX of the Act requires that, in order to receive federal matching funds, any state program must offer certain services to the categorically needy population. Accordingly, Nevada currently provides the following federally-mandated Medicaid services:

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Physician services, medical and surgical dental services;
4. Nursing Facility (NF) services for individuals aged 21 or older who would otherwise be receiving SSI;
5. Home health care for persons eligible for NF services, including medical supplies and appliances for use in the home;
6. Family planning services and supplies;
7. Rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the State plan;
8. Laboratory and x-ray services;
9. Pediatric and family nurse practitioner services;
10. Federally-qualified health center services and any other ambulatory services offered by a federally-qualified health center that are otherwise covered under the State plan;
11. Nurse-midwife services (to the extent authorized under State law);
12. Transportation; and
13. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services for individuals under age 21. This is a preventive health care program for Medicaid eligible children under the age of 21 with the goal of providing the most effective, preventive health care. This is done through the use of periodic examinations, standard immunizations,

diagnostic services, and treatment services which are medically necessary and designed to correct or ameliorate defects in physical or mental illnesses or conditions pursuant to 42 U.S.C. Section 1396d (a) (4) (B). In Nevada, this program (“Healthy Kids”) excludes recipients eligible under the pregnancy-related only category.

### **Optional Medicaid State Plan Services Currently Provided**

Nevada has elected to cover numerous optional services under its Medicaid State Plan. These services are typically provided in a home and community based environment and reduce the overall cost of health care. Pharmacy benefits, for example, are optional services, however, without medication many Medicaid recipients could end up in an acute care hospital at a much higher cost of care. Therefore, Nevada Medicaid offers the following optional services and receives federal funding to do so:

1. Pharmacy;
2. Dental services for those under 21 years of age;
3. Optometry supplies for those under 21 years of age;
4. Psychologist;
5. Physical, occupational, and speech therapies;
6. Podiatry for those under 21 years of age and eligible Qualified Medicare Beneficiaries (QMB);
7. Chiropractic services for those under 21 years of age and eligible QMB;
8. Intermediate care facility services for those 65 years and older;
9. Skilled nursing facility services for those under 21 years of age;
10. Inpatient psychiatric services for those under 21 years of age;
11. Personal care services;
12. Private duty nursing;
13. Nurse anesthetists;
14. Prosthetics and orthotics;
15. Hospice; and
16. Intermediate Care Facility for the Mentally Retarded.

Nevada Medicaid also operates four waivers, authorized by the Secretary of the U.S. Department of Health and Human Services, whose regulations are found in Section 1915(c) of the Act, as discussed below.

### **Medicaid Home and Community-Based Waivers (HCBW)**

Under a federally-approved waiver permitted by Section 1915(c) of the Social Security Act, Nevada has elected to provide optional home and community-based services to certain individuals who are eligible for Medicaid. The waivers are designed to provide Medicaid State Plan services and certain extended Medicaid covered services unique to each waiver to eligible participants. The goal is to allow participants to live in a community setting when appropriate.

The services provided to eligible individuals may include case management, personal care services, respite care services, adult day health care services, homemaker, habilitation, and other services requested by the State and approved by CMS. DHCFP has the flexibility to design the waivers and select the mix of waiver services that best meets the goals of the program. This flexibility is predicated on administrative and legislative support, as well as federal approval. Nevada's Home and Community-Based Services (HCBS) are listed below.

1. HCBS are offered to certain individuals throughout the state with mental retardation and related conditions.

Target Population: Mental retardation or related condition, ICF/MR level of care, waiver service need

Services Offered:

- State Plan Targeted Case Management
- Attendant Care (provided under State Plan Personal Care Services)
- Counseling Services
- Day Habilitation
- Prevocational Services
- Supported Employment
- Counseling
- Residential Habilitation: Direct Support Management
- Behavioral Consultation, Training and Intervention
- Community Integration
- Non-medical Transportation
- Nursing Services

2. HCBS are offered to certain frail elderly persons throughout the state.

Target Population: 65 and over, nursing facility level of care, waiver service need

Services Offered:

- Case Management
- Augmented Personal Care
- Homemaker
- Chore
- Respite Care
- Personal Emergency Response Systems
- Adult Companion
- Adult Day Care (out of home)

3. HCBS are offered to certain physically disabled persons throughout the state.

Target Population: Physically disabled, nursing facility level of care, waiver service need.

Services Offered:

- Case Management
- Attendant Care
- Homemaker
- Chore
- Respite Care
- Home Adaptations
- Personal Emergency Response Systems
- Assisted Living
- Home Delivered Meals
- Specialized Medical Equipment

4. HCBS are offered to certain elderly individuals in assisted living facilities throughout the state.

Target Population: 65 and over, who meet criteria for placement in Assisted Living Facility, nursing facility level of care.

Services Offered:

- Direct Service Case Management
- Augmented Personal Care

Section 6086 of the Deficit Reduction Act of 2005, established a new optional benefit under the State Plan that provides HCBS to certain Medicaid recipients without requiring a 1915(c) waiver. Nevada Medicaid adopted this optional 1915(i) State Plan HCBS benefit option effective July 1, 2007, to allow individuals to access home and community based services through the State Plan without a waiver. Unlike the 1915(c) waivers, individuals do not have to meet an institutional level of care in order to receive these services and States do not have to demonstrate that 1915(i) services cost the same or less than institutional services.

To qualify for HCBS under Nevada's 1915(i) benefit, an individual must meet a needs-based eligibility criteria. Individuals need at least two of the following:

Functional Impairment in:

1. Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) or
2. Cognitive behavior

Risk Factors of:

1. Medical
2. Need for Supervision
3. Substance Abuse
4. Multiple Social System Involvement

Services provided under Nevada's 1915(i) State Plan HCBS benefit option include Adult Day Health Care, Home-Based Habilitation, and HCBS Partial Hospitalization.

### **New Covered Services Available**

Under the NCCW, Nevada will offer new services to eligible recipients. These services include: 1) care management services, 2) medical home services, and 3) health home services.

### **Care Management Services**

Nevada will offer care management services under the NCCW. Care management involves a comprehensive assessment of each recipient to determine every individual's need for care and for coordination. This is based on factors, such as physical, emotional, and psychological health; functional status; current health and health history; self-management knowledge and behaviors; current treatment recommendations, including prescribed medications; and need for support services. An essential component of care management is establishing a usual source of primary care by validating, at time of initial assessment, the recipient's primary care provider (PCP) or facilitating the selection of a PCP if the recipient does not have a routine source of primary care.

Also essential to care management is the establishment and maintenance of mechanisms for the recipient's PCP and other treating providers to be actively involved in the development of a person-centered care plan. The recipient's care plan needs to identify the recipient's current and expected needs, goals for care, and coordination deficiencies. The plan is designed to fill gaps in coordination, establish goals for patient care and, in some cases, set goals for the individual's providers. The person-centered care plan is jointly created, and managed by, a multi-disciplinary health care team (medical and social work personnel) which, at a minimum, includes:

- The recipient and/or the recipient's designee;
- A care manager, assigned to oversee and coordinate chronic care management activities;
- The recipient's PCP;
- Licensed psychiatrist, psychologist, or licensed/certified mental health specialist based on recipient needs;
- A pharmacist based on recipient needs;
- A nutritionist based on recipient needs; and
- Other key clinicians and caregivers as necessary for the recipient's care.

Care management services may also include the following components for specific target populations of Medicaid clients.

- *Disease Management Interventions* - Targeted populations with chronic diseases such as cardiac arterial disease, chronic heart failure, chronic obstructive pulmonary disease, diabetes mellitus and asthma (based on the recipient's age and severity of the underlying conditions) using a risk stratification process. Care management provides one-on-one health coaching with licensed clinical professionals, as well as facilitating behavioral changes by the recipients by addressing underlying health risks such as obesity or weight management. Care management may also involve online coaching tools.
- *Care Management Interventions* - Care management includes clinical interventions to high risk recipients with escalating acute care needs. Nurse-intensive interventions are provided over a defined period of time to resolve exacerbation from co-morbid conditions such as, problems of metabolic and immune system, gout, hyperlipidemia, hypo- and hyper-functioning of parathyroid gland, sex gland disorders, neoplastic disease of blood and lymphatic system except leukemia, non-neoplastic blood disease with splenectomy, and various endocrinological disorders.
- *Complex Condition Management* – Recipients with certain types of conditions such as transplants, burns, and other high cost/high risk conditions are targeted early in their

disease or condition progression to receive very nurse-intensive interventions. They may be managed in select locations to address not only relatively rare conditions, but also conditions which involve a very high treatment cost, often exceeding \$100,000 per year.

- *Oncology Management* – Recipients in this program will receive multiple interactions conducted by a nurse expert in oncology treatment who focuses on specific-cancer related treatment protocols. This program may refer recipients to certain defined facilities or networks of providers.
- *Chronic Kidney Disease Management* - Recipients with Chronic Kidney Disease (CKD) receive interventions, which in some cases can slow the progression of the disease and delay the need for dialysis or transplant, and help prepare recipients for dialysis therapy in the least costly setting. The care management interventions include education on options for treatment, diet, and lifestyle changes. This instruction also consists of preparation for dialysis (including dialysis access placement and in-patient or home dialysis options), standardized evidence-based care pathways and coordinated care processes and protocols which may be accomplished through a defined network of providers.
- *Mental Health Program* - Recipients in this program have a serious and persistent mental health condition, acute mental health problems, or mental health co-morbidity associated with an acute and/or chronic condition. These recipients will receive an initial assessment and follow-up management for behavioral issues, such as depression and other psychiatric problems that hamper their ability to cope effectively with acute and chronic conditions. Care management services promote communication between PCPs and behavioral health providers to ensure that services are coordinated, that duplication is eliminated, and that coordination supports primary care based management of psychiatric medications as medically appropriate. Care management also includes affirmative steps to ensure that recipients with a mental health condition have access to evidence-based mental health treatment and mental health rehabilitative services, such as the Assertive Community Treatment (ACT) and other models supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) through the establishment of referral protocols and treatment guidelines. These services vary based on recipient need and may include one-on-one and in person assistance.
- *Maternity and Neo-Natal Program* - Recipients who are pregnant are identified, preferably in the earliest trimester(s), and receive interventions to reduce the incidence and severity of preterm births through pre-natal education, pre-natal care management and education, and proactive care management of pregnancies considered to be at high risk of premature birth. Care management reduces risk factors to produce a better outcome both before and after the birth. Recipients are also assisted with obtaining access to maternal and child health programs.

## Medicaid Medical Home Services

Under the NCCW, Nevada will offer medical home services through health care providers who contract directly with DHCFP to provide care management services to Medicaid recipients. The intent of this program is to reduce emergency room use, increase preventive care, and improve overall effectiveness, by fostering a close physician-patient relationship. Medicaid medical home services will incorporate the PCMH principles reflected in the Joint Principles developed by the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), and American Osteopathic Association (AOA).<sup>1</sup> In accordance with this joint statement, the Medicaid medical/health homes services should include the following components:

- ***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- ***Physician-directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- ***Whole person orientation*** – the personal physician is responsible for providing for all of the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- ***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- ***Enhanced access*** to care is available through systems such as open scheduling, expanded hours and new options for communication among patients, their personal physician, and practice staff.

## Medicaid Health Home Services

Nevada will also use the NCCW to offer health home services. Medicaid health homes are medical home providers who meet higher standards for care coordination. They also function as comprehensive care management providers across behavioral and long-term care systems. Medicaid health homes provide “comprehensive and timely high quality services” as defined in Section 1945(h)(4) of the Social Security Act. Services provided by the health homes will include:

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<sup>1</sup> [www.medicalhomeinfo.org/Joint%20Statement.pdf](http://www.medicalhomeinfo.org/Joint%20Statement.pdf)

- Provision of quality-driven, cost-effective, culturally appropriate, and person- and family-centered services;
- Coordination with, and access to, high-quality health care services informed by evidence-based clinical practice guidelines;
- Coordination with, and access to, preventive and health promotion services, including prevention of mental illness and substance use disorders;
- Coordination and access to mental health and substance abuse services;
- Coordination and access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
- Coordination with, and access to, chronic disease management, including self-management support to individuals and their families;
- Coordination with, and access to, individual and family supports, including referral to community, social support, and recovery services;
- Coordination with, and access to, long-term care supports and services;
- Development of a person-centered care plan that coordinates and integrates all of an individual's clinical and non-clinical health-care related needs and services;
- Demonstrated capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establishment of a continuous quality improvement program, including data collection and reporting needed to evaluate the effects of the increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and overall quality of care outcomes for the entire population.

## **COVERED POPULATIONS**

### **Current Eligibility for Medicaid**

The State of Nevada has some discretion in determining which groups the Medicaid programs will cover and the financial criteria for Medicaid eligibility. However, to be eligible for federal funds, the State is required to provide Medicaid coverage for most individuals who receive

federally-assisted income maintenance payments, as well as for related groups not receiving cash payments.

The Nevada Department of Health and Human Services (DHHS) currently offers medical assistance through a number of programs for individuals and families:

- Medicaid for persons who qualify for cash assistance, but choose to receive medical benefits only, or who are ineligible to receive cash assistance due to TANF time limits or who are ineligible due to income or resources of an individual(s) who is not their parent or spouse;
- Medicaid coverage from the Child Health Assurance Program (CHAP) for minor children and pregnant women with countable income below certain poverty levels;
- Emergency medical assistance on a month-by-month basis for illegal aliens or other non-citizens not covered in other eligible categories. These applicants must meet TANF or CHAP requirements except for citizenship;
- Pregnant women eligible for Medicaid in any month of pregnancy remain eligible for pregnancy-related and postpartum coverage regardless of changes in income;
- Newborn children remain eligible for Medicaid for one year if the mother was eligible for Medicaid at the time of their birth and would still be eligible if pregnant. The newborn child must continue to reside with the mother in Nevada;
- Medicaid may continue for up to twelve months when TANF ends if: the household becomes ineligible for TANF due to the increased earned income of the caretaker OR loss of earned income disregards; for up to four months if: the household becomes ineligible due to a child or spousal support collection by Support Enforcement;
- Medicaid for household members determined by using separate sub-assistance units (SU) when a child has their own income/resources. The child with income/resources is assigned to their own SU and their income/resources are not prorated or diverted to other sub-assistance groups. The SU separation allows Medicaid to be granted to all or some sub-assistance units;
- Medicaid for uninsured women under age 65 who are identified through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program for further diagnosis or are in need of treatment (Public Law Case); and
- Medicaid for "Independent Foster Care Adolescents" for young adults who have "aged out" of foster care.

Other household members may be eligible for Medicaid from the Medical Assistance for the Aged, Blind and Disabled (MAABD) Program. This program provides medical services for individuals who are eligible through a means-tested public assistance program (i.e., Supplemental Security Income [SSI]). These groups are described below:

- Supplemental Security Income (SSI) recipients;
- Employed individuals, ages 16 through 64, with disabilities and combined net earned and unearned income up to 250% of the federal poverty level (Health Insurance for Work Advancement);
- Nursing facility residents with gross monthly income up to 300% of the SSI payment level (State Institutional Cases);
- Certain individuals who have lost SSI eligibility, but would still be eligible if some of their income were disregarded (Public Law Cases);
- Disabled children who would normally require medical facility care, but can appropriately be cared for at home;
- Aged or physically disabled individuals who require medical facility care, but can appropriately be cared for at home and aged individuals who have been residing in nursing facilities but can appropriately be cared for in adult group care facilities (Home and Community-Based Waivers); and
- Some ineligible aliens or non-citizens who do not meet citizenship eligibility criteria and have emergency medical services may qualify for limited Medicaid coverage.

### **Eligibility for Medicaid Managed Care Organization (MCO) Services**

As previously discussed, certain Medicaid recipients who reside in urban Clark and Washoe Counties are required to enroll in one of the two Managed Care Organizations (MCOs) currently operating in those counties. These recipients will be excluded from the NCCW.

Recipients enrolled in MCOs fall under Title 42, Part 435 of the Code of Federal Regulations (CFRs). Under Subpart B, Mandatory Coverage of the Categorically Needy, these Sections include:

- 435.110 – Individuals receiving aid to families with dependent children

- 435.112 – Families terminated from Temporary Assistance for Needy Families (TANF), (formerly known as Aid to Families with Dependent Children (AFDC)), because of increased earnings or hours of employment
- 435.113 – Individuals who are ineligible for TANF because of requirements that do not apply under title XIX of the Act
- 435.116 – Qualified pregnant women and children who are not qualified family members
- 435.117 – Newborn Children
- 435.145 – Children for whom adoption assistance or foster care maintenance payments are made

However, recipients in these Sections are only enrolled in an MCO if they reside in urban Clark or Washoe Counties. Recipients who do not meet these requirements are part of Nevada Medicaid's fee-for-service population.

### **Eligibility for CMOs and Medicaid Medical/Health Homes**

Phase One of the NCCW will address Medicaid's FFS population who could most benefit from coordinated care and utilization management. Although physicians are likely managing their panels' care appropriately, there generally is no systemic care management taking place. Thus, DHCFP has elected to develop a broad care management initiative for Medicaid FFS members with identified chronic illness. The inclusion criteria for the NCCW eligibility based on diagnosis and regulatory statute is summarized below. The targeted populations are those chronic conditions based on diagnosis (Dx) and disease codes, including:

- Asthma: 493-493.92
- Chronic Bronchitis/Emphysema: 491-492.8
- Diabetes Mellitus: 250-250.9
- End Stage Renal Disease: 584-586
- Heart Disease: 390-459
- Neoplasm: 140-239
- Obesity: 278-278.8
- Mental Health: 290-290.9; 293-298.9; 300-302.9; 306-316

- Substance Abuse: 291.0-292.9; 303.00-305.90
- HIV/AIDS: 042, 079.53, V08

High-risk pregnancies will also be part of the NCCW in order to improve birth outcomes and reduce costs. There may also be additional conditions and utilization patterns added, if the DHCFP feels care management would benefit the enrollee.

Populations to be included are recipients that fall under the Aid to Families with Dependent Children and Aged, Blind and Disabled populations (exceptions include those that are enrolled in a Managed Care Organization or are Dual Eligible for Medicare/Medicaid).

Regulatory and statutory oversight of these recipients is found in Title 42, Part 435 of the CFRs and in Public Law. Under Title 42, Part 435, Subpart B, Mandatory Coverage of the Categorically Needy, recipients covered under the following Sections will be included in the NCCW (unless they meet the requirements to be enrolled in an MCO):

- 435.110 – Individuals receiving TANF (formerly AFDC)
- 435.112 – Families terminated from TANF because of increased earnings or hours of employment
- 435.113 – Individuals who are ineligible for TANF because of requirements that do not apply under Title XIX of the Act
- 435.116 – Qualified pregnant women and children who are not qualified family members
- 435.117 – Newborn Children
- 435.120 – Individuals receiving Supplemental Security Income (SSI)
- 435.121 – Individuals in States using more restrictive requirements for Medicaid than the SSI requirements
- 435.135 – Individuals who become ineligible for cash assistance as a result of Old Age, Survivors, and Disability Insurance (OASDI) cost-of-living increases received after April 1977
- 435.137 – Disabled widows and widowers who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under Pub. L. 98-21

- 435.138 – Disabled widows and widowers aged 60 through 64 who would be eligible for SSI except for early receipt of social security benefits
- Pub. L. 99-643 (Section 1619(b) under the Social Security Act) – Employment Opportunities for Disabled Americans Act
- Pub. L. 105-33 – Section 4913 of the Balanced Budget Act of 1997 - Medicare and Medicaid Provisions, Subtitle J, Chapter 2 - Continuation of Medicaid Eligibility for Disabled Children Who Lose SSI Benefits

Under Title 42, Part 35, Subpart C, Options for Coverage as a Categorically Needy, these Sections will be included in the NCCW:

- 435.211 – Individuals who would be eligible for cash assistance if they were not in medical institutions
- 435.225 – Individuals under age 19 who would be eligible for Medicaid if they were in a medical institution
- 435.236 – Individuals in institutions who are eligible under a special income level

Under Title 20, Part 416, Subpart B, Eligibility, Special Provisions for People Who Work Despite a Disabling Impairment, these Sections will be included in the NCCW:

- 416.266 – Continuation of SSI status for Medicaid
- 416.267 – General
- 416.268 – What is done to determine if you must have Medicaid in order to work

Under Title XIX of the Social Security Act (SSA), these sections will be included in the NCCW:

- Section 1902 – State Plans for Medical Assistance
- Section 1920B – Presumptive eligibility for certain breast or cervical cancer patients

## **Excluded Populations**

Besides those recipients enrolled in Medicaid MCOs, certain other populations will be excluded from the NCCW, as well. Nevada will also exclude individuals enrolled in the State's Mental Retardation and Developmental Disabilities waiver from care management, as well as any individuals receiving Intermediate Care Facility/Mental Retardation (ICF/MR) services.

In Phase One, Medicaid recipients dually eligible for Medicare, those persons receiving case management in 1915 (c) waivers, recipients enrolled in Nevada Check Up, or those individuals in Child Welfare will be excluded. Child Welfare exclusions include recipients eligible under juvenile justice and foster care programs. Additionally, patients receiving Targeted Case Management are excluded from the NCCW.

Regulatory and statutory oversight of these recipients is found in Title 42, Part 435 of the CFRs. Excluded populations include:

- 435.117 and 435.139 – Emergency medical services
- 435.115, 435.117, 435.831 and 435.914 – Prior medical services
- 435.117 and 435.217 – Home and Community Based Waiver (HCBW) services
- 435.145 – Children for whom adoption assistance or foster care maintenance payments are made, including Title IV-E Foster Care

## **Reasons for Exclusions**

Providing care management services under the NCCW to certain populations would significantly impact and/or duplicate services in other existing care management programs. There could be unintended adverse consequences to current clients and the support systems that serve these clients. All of these programs have a demonstrated a record of successfully providing care coordination and case management services, which is why Nevada is choosing to exclude these programs from the NCCW.

### **Division of Aging and Disability Services**

For example, all recipients on the Home and Community-Based Waivers (HCBW) operated by the Division of Aging and Disability Services (ADSD) (1,767 individuals/slots per month) currently receive case management through the HCBW.

Eliminating this direct service could have impacts on the HCBW recipients/HCBW operations. Nevada has a substantial plan for state personal care services. The HCBW is needed for some

individuals, who are transitioning from a nursing facility or being diverted from nursing facility admission, to be eligible for Medicaid and receive the personal care services. Although the HCBW provides a range of services, there are a few HCBW recipients that are only eligible for Medicaid due to the case management services provided by the HCBW. For these recipients, the HCBW allows them to live in the community. If this HCBW service was eliminated, the ADSD would not be able to be a provider of this HCBW service and some recipients could lose their Medicaid eligibility.

This would have the effect of reducing ADSD's budget and service capabilities, thereby resulting in a considerable staff reduction that would significantly hinder the agency's ability to provide effective services to recipients enrolled in the program. This impact would likely increase administrative activities necessary to coordinate care and determine eligibility. Developing and updating Plans of Care, Quality Management documentation, and utilization management with entities outside ADSD could also be hindered. This situation could also create potential obstacles in meeting CMS requirements for these HCBWs.

### **Division of Mental Health and Developmental Services**

Likewise, service delivery for recipients in the Mental Retardation and Related Conditions HCBW operated by the Division of Mental Health and Developmental Services (MHDS) relies on service coordination, which is funded as Targeted Case Management (TCM) under Medicaid's State Plan. It is provided to all recipients of the HCBW for Individuals with Mental Retardation and Related Conditions. Coordination is a vital and essential service component provided to all recipients obtaining services through Developmental Services. MHDS supports individuals throughout Nevada with developmental disabilities and related conditions over their lifespan. Service Coordinators assist recipients in developing comprehensive, person-centered plans focused on meeting the needs of individual recipients and coordinating implementation of their plans. Here too, Service Coordination, as TCM, is an essential service in the implementation of a quality HCBW program and critical for assuring the health and safety of recipients.

Service coordination is also a vital and essential service component provided to MHDS's Serious Mental Illness (SMI) adult individuals statewide and Severe Emotional Disturbed (SED) children/adolescent individuals in all Nevada counties outside of Clark and Washoe counties. Service Coordination is provided to eligible recipients who are residing in a community setting or transitioning to a community setting following an institutional stay. TCM services are vital to discharge planning when transitioning clients out of a hospital into community-based settings, thereby facilitating their continuum of care. Coordinating clients' medical, social, education, housing and other support services and needs can be instrumental for keeping them in the community.

Additionally, to help comply with the SAMHSA's requirements for proving more evidence-based practices for our consumers with mental illness, MHDS has identified the funding resources to facilitate a statewide Illness Management and Recovery (IMR) training. The goal of this training is to instill a new culture of hope in recovery for clients with mental illness. IMR is an intervention that builds confidence in people who have experienced psychiatric symptoms so that they can move forward in their lives. It introduces the concept of recovery and encourages consumers to develop their own definitions of recovery. TCM plays a key component in facilitating IMR principles and interventions.

### **Division of Health Care Financing and Policy**

All recipients on the Home and Community-Based Waiver (HCBW) operated by the Division of Health Care Financing and Policy (579 individuals/slots per month) currently receive case management as a waiver service provided by DHCFP staff.

Eliminating this direct case management service could have impacts on the waiver recipients/waiver operations. Nevada has a robust plan for state personal care service. The HCBW is needed for some individuals, who are transitioning from a nursing facility or being diverted from nursing facility admission, to be eligible for Medicaid and receive the personal care services. Although the HCBW provides a range of services, there are a few HCBW recipients that are only eligible for Medicaid due to the case management services provided by the HCBW. For these recipients, the HCBW allows them to live in the community. If this HCBW service was eliminated, the DHCFP would not be able to be a provider of this HCBW service and some recipients could lose their Medicaid eligibility.

This would have the effect of reducing DHCFP's budget for case management staff payroll and service capabilities, thereby resulting in a considerable staff reduction that would significantly hinder the agency's ability to provide effective services to recipients enrolled in the program. This impact would likely increase administrative activities necessary to coordinate care and determine eligibility. Developing and updating Plans of Care, Quality Management documentation, and utilization management with entities outside DHCFP could also be hindered. This situation could also create potential obstacles in meeting CMS requirements for these HCBWs.

### **County Child Welfare Juvenile Justice Systems**

Incorporating recipients in the Child Welfare and Juvenile Justice Systems into the NCCW would result in duplication of services, thereby producing negative programmatic and financial impacts to the systems. Effects of this could result in a complete loss of Medicaid Targeted Case Management (TCM) revenues in these systems, an average of 10-15% staff statewide, and services that those funds support. County Child Welfare and Juvenile Justice Programs earn Medicaid funds by providing allowable case management activities to Medicaid eligible individuals. There are approximately 1,000 children served by the Child Welfare program in

Washoe County, with another approximately 900 to 1,000 individuals served in the Washoe County Juvenile Services system. There are approximately 4,500 children served under the Clark County Juvenile Justice system, with another approximately 5,000 to 6,000 individuals in the Clark County Child Welfare program.

Medicaid funds for these TCM services and activities are based upon the results of the CMS approved State plan and a federally approved or federally acceptable Cost Allocation Plan. The Plan describes the agency, the financial systems, the documentation processes, the programs, the activities that support each program, and the funding for the multiple activities and programs. These funds are based upon reimbursement of allowable costs and activities associated to the eligible caseload. Currently, the Medicaid TCM caseload and related-activities represent between 18% to 27% of the Juvenile Services and Child Welfare Programs workload. These percentages are projected to increase for both programs based upon the recent approval and implementation of the Medicaid CHAP eligibility process. It is anticipated that the Juvenile Services eligible Medicaid/Nevada Check Up population may increase to approximately 40%-65% of their caseload (based upon recent pilot studies).

The above described Cost Allocation Plan results are used to develop a reimbursement rate. The DHCFP reviews and approves the methodology and rate on an annual basis. Clark and Washoe County Juvenile Justice Programs currently receive approximately \$1,200,000 and \$450,000 per year respectively. The Washoe County Child Welfare Program receives approximately \$2,500,000 per year.

The Federal review and requirements of the Child and Family Service Review (CFSR) program create an additional area of concern. The CFSR is the federal government's review of state child welfare systems. Well-being requirements and external case management for medical coordination, and all other areas of the Department's responsibility, may create a barrier to providing seamless management to meet federal CFSR requirements. If a state does not meet these requirements, it must develop a Program Improvement Plan to improve those areas. If the agreed upon activities are not met, a state could face financial penalties, and result in reduced funds available for use in programs for recipients.

### **Health Division**

Federal law mandates that 100% of all children qualifying for Early Education Part C services must have service coordination, which is administered by the Health Division. Therefore, including Part C children in the NCCW could have unintentional consequences.

### **Overall Exclusions**

The excluded programs referenced above have successfully managed the care of their clients, which is why it would not be beneficial to move these recipients into the NCCW until the NCCW has proven to be as effective, if not more so, than these other programs. In addition, if

the funds from Medicaid used to pay for these programs were no longer available to be earned because duplicative case management services were being provided under the NCCW, all of these service delivery systems would have to be modified by cutting services, operating costs, and/or staff. Due to the difficult economic times, services and staffing have already been negatively impacted in many of these specialized delivery systems. The State of Nevada has elected to exclude clients receiving these services in order to avoid the potential loss of these necessary services and supports, which could result from the implementation of the NCCW in these areas.

The Emergency Medical Only Program and Native Americans Program would continue to be excluded from mandatory managed care options under the NCCW. Native Americans could be offered an opportunity to voluntarily opt into one of the managed care choices (such as MCOs, the CMO, or Medicaid medical/health homes).

# BUDGET NEUTRALITY

## 5 YEARS OF HISTORIC DATA

### SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	5-YEARS
<u>TANF/CHAP Pop 1</u>						
TOTAL EXPENDITURES	\$ 143,778,084	\$ 146,002,301	\$ 161,588,359	\$ 194,071,308	\$ 231,607,362	\$ 877,047,414
ELIGIBLE MEMBER	363,390	401,058	450,593	512,809	561,919	
MONTHS						
PMPM COST	\$ 395.66	\$ 364.04	\$ 358.61	\$ 378.45	\$ 412.17	
TREND RATES						5-YEAR
						AVERAGE
TOTAL EXPENDITURE		1.55%	10.68%	20.10%	19.34%	12.66%
ELIGIBLE MEMBER		10.37%	12.35%	13.81%	9.58%	11.51%
MONTHS						
PMPM COST		-7.99%	-1.49%	5.53%	8.91%	1.03%

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	5-YEARS
<u>MAABD Pop 2</u>						
TOTAL EXPENDITURES	\$ 515,589,687	\$ 516,082,155	\$ 548,966,555	\$ 595,981,494	\$ 659,671,222	\$ 2,836,291,112
ELIGIBLE MEMBER	146,273	150,405	156,585	167,710	170,913	
MONTHS						
PMPM COST	\$ 3,524.85	\$ 3,431.28	\$ 3,505.87	\$ 3,553.64	\$ 3,859.69	
TREND RATES						5-YEAR
						AVERAGE
TOTAL EXPENDITURE		0.10%	6.37%	8.56%	10.69%	6.35%
ELIGIBLE MEMBER		2.82%	4.11%	7.10%	1.91%	3.97%
MONTHS						
PMPM COST		-2.65%	2.17%	1.36%	8.61%	2.29%

**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION**

MEDICAID POPULATIONS (If no existing Medicaid populations will participate in the demonstration, leave blank.)										
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR FY 2011	TREND RATE 2	DEMONSTRATION YEARS (DY)				TOTAL WOW	
					FY 2013	FY 2014	FY 2015	FY 2016		FY 2017
<b>TANF/CHAP Pop 1</b>										
Eligible Member Months	11.51%		561,919		626,596	698,717	779,140	868,819	968,820	
PMPM Cost Total	1.03%		\$ 412.17		\$ 416.42	\$ 420.71	\$ 425.04	\$ 429.42	\$ 433.84	
Expenditure					\$ 260,927,194	\$ 293,957,412	\$ 331,165,586	\$ 373,088,171	\$ 420,312,803	\$ 1,679,451,167
<b>MAABD Pop 2</b>										
Eligible Member Months	3.97%		170,913		177,698	184,752,7908	192,087	199,713	207,642	
PMPM Cost Total	2.29%		\$ 3,859.69		\$ 3,948.08	\$ 4,038.49	\$ 4,130.97	\$ 4,225.57	\$ 4,322.34	
Expenditure					\$ 701,566,604	\$ 746,122,298	\$ 793,507,603	\$ 843,902,738	\$ 897,499,190	\$ 3,982,598,433

**NOTES**

"Base Year" is the year immediately prior to the planned first year of the demonstration.

"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year. The default is to use the 5-year historical average trend.

"Months of Aging" equals the number of months of trend factor needed to trend from the last year to the Base Year. If the base year is the year immediately following the last historical year, Months of Aging" will be 12.

"Trend Rate 2" is the trend rate that projects all DYs, starting from the Base Year. The default is to use the 5-year historical average trend. For hypothetical populations, without-waiver estimates are set by default to equal the with-waiver estimates.

**DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION**

**MEDICAID POPULATIONS (Should be blank-filled if no existing Medicaid populations will be in the demonstration.)**

		DEMONSTRATION YEARS (DY)					TOTAL WW
ELIGIBILITY GROUP	BASE YEAR FY 2011	DEMO TREND RATE	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>TANF/CHAP Pop 1</b>							
Eligible Member Months	561,919	11.51%	626,596	698,717	779,140	868,819	968,820
PMPM Cost	\$ 412.17	-5.00%	\$ 391.56	\$ 371.98	\$ 353.38	\$ 335.71	\$ 318.92
Total Expenditure			\$ 245,350,013	\$ 259,908,912	\$ 275,332,427	\$ 291,671,161	\$ 308,976,026
<b>MAABD Pop 2</b>							
Eligible Member Months	170,913	3.97%	177,698	184,753	192,087	199,713	207,642
PMPM Cost	\$ 3,859.69	-5.00%	\$ 3,666.71	\$ 3,483.37	\$ 3,309.20	\$ 3,143.74	\$ 2,986.55
Total Expenditure			\$ 651,567,669	\$ 643,562,329	\$ 635,655,878	\$ 627,846,845	\$ 620,133,124
							\$ 3,178,765,844

**NOTES**

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.  
 New hypothetical populations are shown in both without-waiver and with-waiver projections.  
 New non-hypothetical populations only appear in the with-waiver projections. The State must show offsetting Medicaid savings to achieve budget neutrality.  
 "Demo Trend Rates" are a blended rate reduction that accounts for Waiver and Non-Waiver population and Waiver Capitation payments to achieve budget neutrality.

**Budget Neutrality Summary**

**Without-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	
TANF/CHAP Pop 1	\$ 260,927,194	\$ 293,957,412	\$ 331,165,586	\$ 373,088,171	\$ 420,312,803	\$ 1,679,451,167
MAABD Pop 2	\$ 701,566,604	\$ 746,122,298	\$ 793,507,603	\$ 843,902,738	\$ 897,499,190	\$ 3,982,598,433
Medicaid Pop 3	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pop 1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pop 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	\$ 962,493,798	\$ 1,040,079,710	\$ 1,124,673,189	\$ 1,216,990,909	\$ 1,317,811,993	\$ 5,662,049,600

**With-Waiver Total Expenditures**

	DEMONSTRATION YEARS (DY)					TOTAL
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	
TANF/CHAP Pop 1	\$ 245,350,013	\$ 259,908,912	\$ 275,332,427	\$ 291,671,161	\$ 308,976,026	\$ 1,381,238,538
MAABD Pop 2	\$ 651,567,669	\$ 643,562,329	\$ 635,655,878	\$ 627,846,845	\$ 620,133,124	\$ 3,178,765,844
Medicaid Pop 3	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pop 1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Pop 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
New Pop 1	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
New Pop 2	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL</b>	\$ 896,917,682	\$ 903,471,241	\$ 910,988,304	\$ 919,518,006	\$ 929,109,150	\$ 4,560,004,382
<b>TOTAL</b>	\$ 65,576,117	\$ 136,608,470	\$ 213,684,885	\$ 297,472,903	\$ 388,702,843	\$ 1,102,045,218

## IMPLEMENTATION TIMELINE

As discussed throughout this document, Nevada plans to use the NCCW to implement a comprehensive care management program. This initiative includes the establishment of a CMO, as well as Medicaid medical homes and health homes. Nevada intends to develop these various care management options, in addition to the Medicaid MCOs currently available to TANF and CHAP recipients in selected areas of the state.

In Phase One, Nevada is seeking flexibility to implement a variety of care management delivery and financing arrangements. Ultimately, by the end of Phase One in June of 2013, the majority of TANF and CHAP recipients, as well as the recipients already part of the program, would receive comprehensive care coordination under a care management option, either through “managed” FFS arrangements or MCO plans, that address:

- Primary medical care;
- Acute medical services;
- Long-term care (home and community based services and nursing facility care); and
- Behavioral health services.

In July 2012, primary and acute medical care for most TANF and CHAP populations will continue to be coordinated through Medicaid MCOs. Beginning August/September 2012, the Medicaid FFS populations with chronic conditions, severe mental health issues, high-risk pregnancies, or patterns of utilization that could benefit from care management, will receive care coordination through the CMO unless enrolled in a designated Medicaid medical home/health home. As part of the CMO scope of work, coordination with a designated PCP will be required to promote integration of behavioral health and physical health. Medicaid medical homes with demonstrated capacity to provide overall care coordination, in addition to the responsibility for coordinating primary care, will be expanded to comprehensive Medicaid health homes by integrating care management for behavioral health services with long-term supports and services. Medicaid medical home pilots would be implemented in the September 2012 timeframe; Medicaid medical home and health home expansion would continue through the waiver period.

Phase Two begins in July 2013, when Nevada will leverage the expanded “managed” FFS infrastructure to increase the enrollment of high-needs, high-cost clients in managed care options by:

- Expanding care management, where deemed beneficial, to the TCM, Child Welfare and HCBW recipients. Enrolling HCBW recipients in the CMO or health homes may require moving 1915 (c) programs under the NCCW since the HCBW case management is also

the HCBW eligibility service, in some cases, that enables individuals to gain HCBW eligibility and State Plan Personal Care Services. Nevada will explore consolidating all HCBW services into one pool, which would provide a coordinated, comprehensive (non duplicative) quality management program.

- Determining if it is beneficial to require mandatory enrollment of dual-eligible Medicaid/Medicare recipients into a care management or managed care option, once DHCFP and CMS have explored the development an integrated care program. This may involve special Medicare waivers to share savings from care coordination with the Federal government or the development of integrated plans through use of Medicare Advantage Special Needs Plans. Such integrated care programs are being designed in a number of states. Nevada has submitted a Letter of Intent to the Medicare-Medicaid Coordination Office within CMS indicating interest in testing new payment and financing models to promote better care and align the incentives for improving care and lowering costs between Medicare and Medicaid.
- Requiring mandatory enrollment of Children with Special Health Care Needs, when deemed beneficial to the child, in a managed care option, including:
  - Blind/Disabled Children and Related Populations (eligible for SSI under title XVI);
  - Eligible under section 1902(e)(3) of the Social Security Act;
  - In foster care or other out-of-home placement;
  - Receiving foster care or adoption assistance under Title IV-E of the Social Security Act; or
  - Receiving services through a family-centered, community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act.

## **PUBLIC INPUT PROCESS**

### **Overview**

Nevada has spent a number of years researching methods and approaches for effectively managing the care of the Medicaid's highest-need recipients. This initial research was highlighted in the previous sections of this Waiver, titled "Previous Care Management Efforts" and "Exploration of PCMH Approaches." More recent activities are described in this section.

## **Legislative Activities**

### **2011 Legislative Actions**

The 2011 Legislative Session supported the development of a care management process that would improve care while providing state savings through program efficiencies. The Legislative Session's final State budget accounted for a State General Fund budget savings in the DHCFFP Medicaid budget of \$4,554,581 for State Fiscal Year 2013. These savings were expected to be achieved through the implementation of a care management and health home program as outlined in a program analysis provided to the State by Public Consulting Group, Inc (PCG). In its report, "State of Nevada Division of Health Care Financing and Policy Care Management and Patient-Centered Medical Home: Opportunities for Quality Improvement and Cost Containment in the Medicaid FFS Population," PCG noted the high utilization rates experienced by Nevada's FFS population and the potential for savings through implementation of care management within this population. PCG also identified specific opportunities for improved quality outcomes, as well as the savings that could be achieved by establishing care management and health homes by developing new processes such as provider incentives, shared savings arrangements, clinical interventions, avoidable readmissions, and emergency room usage reductions.

### **Future Legislative Actions**

It is not expected that any of the activities/programs under the NCCW will require legislative action, or regulation. The overall DHCFFP budget receives legislative approval/authority on a biannual basis. However, the NCCW is expected to be cost neutral, so additional budget authority and/or legislative approval should not be required.

### **Solicitation of Stakeholder Input**

Nevada had initially planned to submit a State Plan Amendment (SPA) to implement the new care management programs. However, soon after the 2011 Legislative Session had concluded, input from statewide stakeholders and the Governor's Office determined that the NCCW was actually needed. It was decided that this was necessary to prevent duplication of services and to preserve the State programs previously discussed in this document who were serving Medicaid recipients. In addition, the NCCW allows for the development of a creative approach to care management and health home programs.

Over the past year, numerous outreach efforts to obtain and incorporate stakeholder input have been employed by the State to ensure that the background, potential impacts, and purpose of the NCCW were understood by the various public and private communities that may be affected by the NCCW. These outreach efforts were intended to ensure that the State appropriately developed and successfully implemented the proposed programs. Activities have included

workshops, presentations, consultations, meetings, and conference calls. The DHCFP's website has also remained up-to-date with relevant documents and planning materials.

For starters, the DHCFP Medical Care Advisory Committee (MCAC) was established, in accordance with 42 CFR 431.12, to ensure that adequate community and provider input is obtained regarding decisions affecting the levels and types of services covered under the State's Medicaid program. The proposed NCCW is an example of the types of programs that the MCAC reviews and monitors, expecting a high level of stakeholder input. The MCAC is comprised of nine (9) members including health care professionals, other providers, and consumers, all of whom offer specialized advice on various components of Medicaid, including the NCCW. DHCFP frequently utilized the MCAC as a vehicle for input in developing approaches to alternative managed care arrangements. One of the MCAC members represents the Indian Health Board. Members of the public were also encouraged to participate in these meetings.

Examples of other outreach efforts that have been undertaken are listed below:

- Multiple discussions occurred with these organizations:
  - SAMHSA
  - Early Intervention Services – Part C
  - University of Nevada School of Medicine
  - Renown Health (a not-for profit integrated health network and hospital system)
  - Nevada Health Centers (a Federally Qualified Health Center)
  - Other provider organizations and advocacy groups
  
- Presentations were given to these organizations:
  - Nevada Division of Aging and Disability Services
  - HealthInsight (a private, non-profit community-based organization dedicated to improving the healthcare systems of Nevada)
  - Great Basin Primary Care Association
  - Southwest Medical Group
  - Nevada Commission on Services for Persons with Disabilities
  - University Medical Center
  - Health Access Washoe County (HAWC) (a Federally Qualified Health Center)
  - Amerigroup and Health Plan of Nevada (the two Medicaid-contracted MCOs)
  - A variety of other medical providers, including dialysis providers and behavioral health specialists
  
- Two Public Workshops and Presentations were held in the Fall of 2011: one for providers and one for recipients and stakeholders; attendees included:

- Washoe County Juvenile Justice
  - Clark County Social Service
  - Washoe County Social Service
  - AARP
  - Washoe Legal Services
  - Governor's Commission on the Disabled
  - Various State Agencies representing Aging and Disabled, Intellectually Challenged, Developmentally Delayed, Persons with Mental Illness, Early Intervention Services, Child Welfare and Children with Several Emotional Disturbance, and Public Health organizations
- Another Public Workshop was held on March 15, 2012 to go over the updated concept for the NCCW
  - Announcement and documentation was sent to the Reno-Sparks Tribal Health Center
  - Letter was sent to the Inter-Tribal Council of Nevada and Indian Health Board of Nevada
  - All Tribes are notified of Public Hearings, as well as Public Workshops, for comment

Stakeholder input is vital to the success of the NCCW, and the DHCFP will continue to strive for ongoing community input. Additional workshops and public outreach programs will be conducted throughout 2012 as implementation draws closer to ensure recommendations and ideas received in the past were addressed in DHCFP's plans for the NCCW.

## **ACCOUNTABILITY AND MONITORING**

### **Quality Strategy**

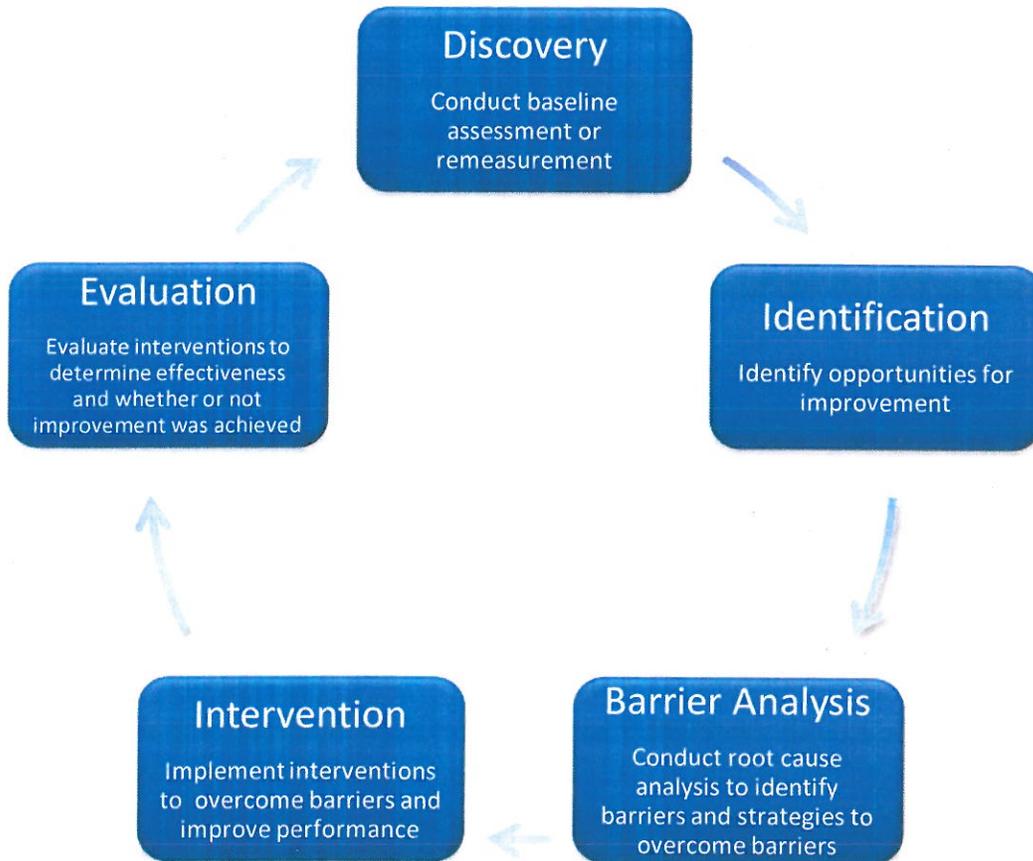
The State of Nevada will retain all of its existing requirements and systems related to ensuring quality of care and promoting quality improvement. Nevada will continue to comply with all CMS requirements related to licensure, survey and certification, accreditation, training, provider enrollment and re-enrollment screening, and quality assurance reviews of practitioners and organizations participating in Nevada's Medicaid program.

### **Quality Improvement Program**

The DHCFP quality improvement program embodies a continuous quality improvement (CQI) process and problem-solving approach that is applied to specific and measurable performance indicators and operational activities. The CQI process is used to: (1) monitor access to care,

timeliness and quality of care, and operational performance; (2) identify opportunities for improvement that exist throughout the Nevada Medicaid program; (3) implement intervention strategies to improve outcomes and performance; and (4) evaluate performance to ensure that interventions were successful. The process employed to review findings from discovery activities, establish priorities, conduct barrier analyses, develop strategies for intervention and improvement, and evaluate performance is depicted below.

### DHCFP Performance Improvement Process Flow



DHCFP uses several key interventions to drive quality improvement in the Nevada Medicaid program, which include:

- Maintaining a robust quality improvement framework that encompasses a continuous quality improvement approach, as described above.
- Using HEDIS and other performance measures to continually assess achievement of goals and objectives.

- Implementing Performance Improvement Projects (PIPs), which measure and assess targeted performance improvement interventions on specific topics.
- Monitoring satisfaction data to determine if Nevada Medicaid recipients are satisfied with care and services.
- Monitoring any vendor's quality improvement activities and compliance with contractual requirements to verify if they are appropriately implementing federal and State contractual standards.
- Facilitating cross-agency collaborative meetings to identify opportunities to improve care and service delivery in the Nevada Medicaid program and achieve stakeholder buy-in to implement interventions to improve care and service delivery.
- Benchmarking performance measure results to ensure that performance is comparable or better than the national norm.
- Implementing other initiatives, as needed, to adhere to changes in federal policy.

The DHCFP works closely with their External Quality Review Organization (EQRO) throughout the year to support, oversee, and monitor quality activities and evaluate the Nevada Medicaid program's achievement of goals and objectives. The EQRO provides ongoing technical support to the DHCFP in the development of oversight monitoring strategies. The EQRO also works with the DHCFP to ensure that Medicaid MCOs stay informed about new State and federal requirements and the evolving technologies for quality measurement and reporting.

The DHCFP intends to use the EQRO to assist in the monitoring and evaluation of key components of the NCCW, including the CMO vendor. The EQRO has already assisted the DHCFP with identifying and creating a set of quality indicators to be included in the CMO RFP to track the bonus payment for the CMO and track quality and utilization of services provided to members who participate in the program. They will also apply the quality indicators to the CMO program.

Once the CMO vendor has been selected by the DHCFP, but prior to the CMO accepting enrollment information from the DHCFP, the EQRO will conduct a readiness review of the CMO. This will verify that the CMO has an appropriate operational structure to oversee the care coordination of Medicaid services to program participants and meet the structural, operational, and administrative requirements of the contract. The EQRO's readiness review will include a report of findings that also includes recommendations to assist the DHCFP and the CMO determine what, if any, operational and structural areas need to be strengthened prior to enrolling members. After the CMO enrolls members and operates within the program for a period of time, the EQRO will also conduct a review of the CMO's compliance with contract standards.

In addition to the EQRO, Nevada might partner with other entities, such as the Nevada System of Higher Education, to monitor and evaluate other aspects of the NCCW. The DHCFP is committed to developing a high-quality program that meets the needs of the recipients, the State, and CMS.

### **Existing Quality Assurance and Quality Improvement**

DHCFP will continue to ensure that providers enrolled in Medicaid meet all CMS requirements. The State will continue to ensure compliance with the quality assurance and performance improvement requirements for MCOs under 42 CFR 438.200. The State will abide by any quality improvement strategies established prior to the NCCW, which will remain in place until changes are approved by CMS. The State will provide summaries to CMS of independent EQRO reports, State quality assurance monitoring, and any other documentation that CMS requires to oversee current quality of care and to facilitate oversight by Nevada's QIO.

### **Quality of Care under the NCCW**

Nevada is not seeking waivers of any CMS requirements related to quality of care, quality improvement, or any other health and safety standards under the NCCW. The State is seeking to strengthen, not curtail, its efforts to promote quality of care under the NCCW, to achieve better treatment outcomes for patients, and to encourage more efficient patterns of care.

The State anticipates that quality of care will be a leading agenda item on its monthly conference calls with CMS under the NCCW. The State's quarterly reports to CMS on the NCCW will address any significant issues that CMS might raise concerning quality of care and will include any updates on quality assurance and monitoring activities under the NCCW that CMS requests. The State's annual reports on the NCCW will also include qualitative findings and the State will seek to facilitate qualitative elements of the independent evaluation of the NCCW.

### **Quality Assurance and Quality Improvement Goals under the NCCW**

The CMO and Medicaid medical/health homes established under the NCCW will be required to promote improved access, continuity, cost-effectiveness, and quality of care. The new care management entities under the NCCW will be required to work collaboratively with the State, its EQRO, and other contracted entities on a wide range of quality monitoring and evaluation activities. Both the CMO and Medicaid medical/health homes will implement ongoing quality assessment and performance improvement programs including systematic activities undertaken under their medical directors to monitor and evaluate care based on pre-determined, objective standards. The accountable entities will be required to help implement effective improvements as needed.

## **Information and Choice**

The DHCFP believes that one of the guiding principles of a successful care management system is insuring that recipients are provided with adequate and timely information to make informed health care choices and access health services. To this end, the CMO and Medicaid medical/health homes must have written information about services and access to services available upon request to recipients. The written information must also be available in the prevalent non-English languages, as determined by the State. Free, oral interpretation services will be available to each NCCW enrollee and potential enrollee. All written material directed to enrollees and potential enrollees must be approved by the DHCFP prior to distribution, and all written material will be in an easily understood format.

MCOs and the CMO must provide all enrollees with an Enrollee Handbook. The handbook must be written at no higher than an eighth (8th) grade reading level. In addition, the handbook will be updated at least once per year. The accountable entity will furnish the handbook to all enrollees within five (5) business days of receiving notice of the recipient's enrollment and will notify all enrollees of their right to request and obtain this information at least once per year or upon request

The CMO must also develop appropriate alternative methods for communicating with visually and hearing-impaired enrollees, and accommodating physically disabled recipients in accordance with the requirements of the Americans with Disabilities Act of 1990. All enrollees and potential enrollees will be informed that this information is available in alternative formats and how to access those formats. The CMO will be responsible for effectively informing eligible Medicaid recipients regarding the Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) services program.

## **Beneficiary Protections**

The State of Nevada will continue to provide beneficiary protections and guarantee the rights of enrollees in compliance with CMS requirements related to:

*Right to apply* – All Nevada residents will retain the right to apply for Medical Assistance under the new program without delay. The State will make available written information on the eligibility requirements and the services for each Medicaid program.

*Application* –Medicaid applications will be made in writing or electronically through ACCESS NEVADA to the Division of Welfare and Supportive Services. Applicants may be assisted in the process by an individual(s) of their choice.

*Timely determination of eligibility* – Nevada will continue to adhere to the federally established timeframes for determining eligibility and informing applicants of what those timeframes are (90 days for applicants who apply on the basis of disability and 45 days for all other applications).

*Notice of decision concerning eligibility* – Nevada will send each applicant a written notice of the agency's decision on their application. If the application is denied the notice will include the reasons for the denial and an explanation of the applicant's right to a fair hearing.

*Timely and adequate notice concerning adverse actions* – Nevada will continue to give Medicaid recipients timely and adequate notice of proposed actions to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may be receiving under Medicaid.

*Fair hearings* – Nevada will continue to operate its fair hearing system for all applicants and enrollees in the Medicaid program. The system will provide for a hearing before the agency, or a local evidentiary hearing at the local level, with a right of appeal to the state agency. The hearing system will meet federal due process standards.

*Notice of Hearing decisions* – Nevada will notify beneficiaries following the hearing of the state's decision and their options for further appeal, if any.

With regard to care management, communications are a two-way street. Recipients and providers must always have a forum where their concerns and grievances can be communicated back to the CMO. Possible issues for grievances include access to care, quality of services, interpersonal relationships between CMO staff and enrollees, and failure to respect an enrollee's rights, in addition to others.

The CMO will establish a grievance process for enrollees, and access to the State Fair Hearing system. In addition, the CMO must establish a similar system to resolve disputes with providers. The CMO must provide information about these systems to enrollees at the time of enrollment and to providers and subcontractors. The CMO is required to maintain records of grievances, complaints and disputes, which the State will review as part of the State's quality strategy. A recipient may file a grievance either orally or in writing. If a grievance is filed orally, the CMO is required to document the contact for tracking purposes and to establish the earliest date of receipt.

The CMO must ensure that the operation of its systems and handling of confidential information is performed in accordance with state and federal regulations related to security and confidentiality, and meet all privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act). All protected health information (PHI) that is accessed, used, stored or transmitted shall be in accordance with HIPAA. Furthermore, all social security numbers, employer taxpayer identification numbers, drivers license numbers, and any other numbers or information that can be used to access a person's

financial resources are “personal identifying information” that must be protected in accordance with Nevada Revised Statutes. Pursuant to these requirements, the CMO will execute a HIPAA Business Associate Addendum

## **Reporting**

DHCFP will continue to comply with all existing CMS reporting requirements and will satisfy any special reporting requirements that CMS selects to facilitate monitoring and evaluation of the NCCW. The State assures CMS that it will meet all financial reporting requirements under Medicaid, all managed care reporting requirements under 42 CFR Part 438, and all reporting requirements that CMS deems necessary in order to monitor the impact and budget neutrality of the NCCW and to facilitate the implementation of an evaluation plan for the NCCW that will meet the needs of CMS. The State will require that all vendors selected to participate under the NCCW submit timely, accurate, and comprehensive reports to the State.

### **Existing CMS Reporting Requirements**

The State assures CMS that it will continue to meet all of the existing, standard financial reporting requirements, including but not limited to the requirements under section 2500 of the CMS State Medicaid Manual concerning the use of the Medicaid and Children’s Health Insurance Program Budget and Expenditures System (MBES/CBES), CMS-64 quarterly expenditure reports, CMS-64.9 quarterly reports on expenditures for waiver services, CMS-64.10 quarterly reports on waiver administration expenditures, CMS-64.21 quarterly reports on CHIP, and CMS-37 quarterly estimates on expenditures for upcoming quarters. NCCW expenditures will be reported per CMS instructions under the project numbers that will be assigned by CMS. Nevada is not seeking waivers of any existing CMS reporting requirements.

### **Special Quarterly Reports to CMS on the NCCW**

DHCFP will submit quarterly progress reports on the NCCW in a format acceptable to CMS within 60 days following the end of each quarter. These quarterly reports may include updates on significant events occurring in the past quarter or expected to occur in the next quarter, such as procurement actions on care management and Medicaid medical home contracts for high cost recipients, revisions to benefits, provider and recipient enrollment activity, grievances and appeals, audits, any significant issues raised concerning access to care or quality of care, and pertinent state legislative activity. These quarterly reports will also include appropriate corrective action plans with respect to any significant administrative or policy issues identified in the quarter, updates on quality assurance and monitoring activities, evaluation activities, and interim findings as such findings become available.

### **Special Annual Reports to CMS on the NCCW**

DHCFP will submit draft annual reports on the NCCW to CMS within 60 days after the end of each year documenting the status of each of the NCCW initiatives, significant accomplishments, quantitative and qualitative findings, utilization data, expenditure data, and updates on any significant administrative or policy issues over the past year. The State will submit the final annual report to CMS within 30 days after receiving comments from CMS on the draft report. The State will ensure that any concerns raised by CMS are fully addressed in the final report.

### **Monthly Conference Calls with CMS on the NCCW**

The DHCFP will participate in conference calls with CMS throughout the NCCW, covering all issues that either party proposes to discuss. The State anticipates that these conference calls will occur monthly or more frequently if CMS or Nevada deems greater frequency to be necessary. An agenda for each call will be developed in collaboration with CMS and disseminated to key staff before each call. Action items and appropriate target dates will be identified jointly with CMS and circulated to key staff after each call to ensure prompt, effective resolution of any issues identified by CMS or the State and timely reporting of appropriate corrective action to CMS using reporting templates acceptable to CMS.

### **Reports from Vendors to the State**

The CMO selected to participate under the NCCW will be required to describe their approach for producing required reports to the State, including methods for validating data included in their reports and contractual assurances that all required reports will be submitted to the State within required timeframes. These CMO reports will include enrollment reports, enrollee service utilization reports, quality assurance reports, grievance and dispute resolution reports, enrollee satisfaction reports, and reports on instances of suspected fraud or program abuse. The State will analyze these reports for purposes of overseeing contract compliance, for purposes of the State's monthly conference calls with CMS, and for purposes of its quarterly and annual reports to CMS. These CMO reports to the State will also be available to CMS on request and will be available to facilitate the implementation of the evaluation plan.

Adequate data reporting capabilities are critical to the ability of CMS and DHCFP to effectively evaluate the NCCW. The success of the program will depend upon whether recipients have better access to care, including preventive services, and experience improved health status, outcomes, and satisfaction within a "managed" Fee-for-Service health care delivery system. To measure the program's accomplishments in each of these areas, the CMO will provide DHCFP with uniform utilization, cost, quality assurance, and recipient satisfaction and grievance/appeal data on a regular basis. It will also cooperate with DHCFP in carrying out data validation steps. Standard reports will include:

*Enrollee Stratification Report* - documents the CMO's Vendor's initial claims based risk assignment of the Membership File and shows a comprehensive stratification of the enrolled population.

*Enrollee Contact Report* – documents the CMO's case management services rendered and encounters for all Enrollees.

*Call Center and Nurse Triage Report* - documents the CMO's call center statistics.

*Provider Engagement Report* - documents the CMO's arrangements with providers regarding care coordination for Enrollees.

*Summary Enrollee Utilization Report* - documents the patterns of health care service utilization among Enrollees.

*Provider Profiling Report* - documents the patterns of professional behaviors of individual practitioners using clinical guidelines.

*Quality Assurance Report* - documents performance relative to Quality Assurance Standards

*Grievance, Complaint and Dispute Resolution Report* - reports the number and types of Enrollee grievances, provider complaints and disputes received by the Awarded Vendor.

*Satisfaction Survey* - collection and submission to DHCFP of a statistically valid uniform data set measuring recipient satisfaction prior to the third quarter of each contract year.

*Fraud and Abuse* - informs DHCFP of any suspected recipient fraud or abuse. The Awarded Vendor will provide immediate notification to DHCFP Business Lines Unit and Surveillance and Utilization Review (SURS) Unit regarding all suspected recipient and provider fraud and abuse.

*Other Reporting* - additional reporting requirements upon the request of DHCFP.

## **EVALUATION**

### **Evaluation Objectives**

The State of Nevada will evaluate the impacts to the quality and cost of care of mandatory enrollment in specific managed care products and specific care management initiatives for certain high cost recipients. The DHCFP will also incorporate the evaluation of the expanded use of electronic health record technology on care management and Medicaid medical homes.

## **Research Questions/Hypotheses**

DHCFP is currently designing the evaluation plan for the NCCW. The below paragraphs provide details regarding the evaluation plan.

The evaluation design will address the research questions listed below.

1. Does enrollment in a Medicaid medical/health home pilot improve the quality of care?
2. Does enrollment in a care management organization improve the quality of care?
3. Does enrollment in a Medicaid medical/health home pilot provide cost efficiencies for Medicaid?
4. Does enrollment in a care management organization provide cost efficiencies for Medicaid?
5. Are recipients satisfied with the care they receive from the care management organization?
6. Are recipients satisfied with the care they receive from their Medicaid medical/health home?

## **Data Sources**

In addition to the data available through the Medicaid Management Information System (MMIS), the CMO will have a MIS capable of documenting administrative and clinical procedures while maintaining the privacy and confidentiality requirements pursuant to HIPAA. The MIS system will also substantiate and report the CMO's compliance with the Contract requirements. The CMO will facilitate the meaningful use of Health Information Technology and Health Information Exchange and make use of resources such as the Electronic Health Record (EHR) incentive program, the State Regional Extension Center to HIT/HIE, and the Department of Health and Human Services' Office of HIT/HIE.

## **Methodologies**

The DHCFP plans to submit a detailed evaluation design for overall evaluation of the NCCW within 120 days of CMS approval. The evaluation design will include research questions and outcome measures that will evaluate the impact of the NCCW. An important aspect of the NCCW will be to use the research data for multiple purposes related to the cost and quality impacts of high cost case management strategies and to isolate the impact on care coordination through the use of electronic health record technology. Nevada is participating in the payment of incentives to Medicaid providers that adopt/implement/upgrade and ultimately become meaningful users of electronic health record systems. Conventional wisdom states that improvements in care coordination will result in improvements to the patient quality of care, that cost efficiencies will be realized by the care coordination, and that care coordination will be improved by implementing an electronic infrastructure. The NCCW will provide qualitative and quantitative evidence of the impacts of care coordination on high cost case management, and the

impacts of the use of electronic transmission of data on care coordination. The NCCW will evaluate the impacts to coordinating care using standardized electronically available data.

This data and the results will provide information for the future planning, implementation and expansion of Medicaid medical homes/health homes in the Nevada Medicaid health care delivery system. This information is especially important for the Nevada Medicaid program as it plans for Medicaid expansion in 2014.

Each of the research questions listed above will have a specific set of quantitative and qualitative research methodologies that are designed to provide a specific plan for each question. Specifically, sets of data points will be gathered and examined, and conclusions, recommendations, and or additional studies, will be identified. The following is a list of items that will be considered and included if appropriate for each research question:

1. Outcome measures;
2. Baseline and/or control comparisons;
3. Data sources and data collection methods, including frequency. The NCCW will have the benefit of being able to use MMIS data, CHIP data, CMO data, medical home data, QIO data and statewide HIE data (when available). The richness of the data sources will provide the ability to design a robust set of data points for analysis;
4. Data sampling designs ( e.g. before and after studies, comparison group analyses);
5. Levels of analysis – The question may require consideration of the Medicaid recipient, the provider, as well as the Nevada Medicaid Program.
6. Cost estimates for each research question evaluation plan;
7. Timeline for deliverables from the research.

The proposed draft evaluation plan that includes the detailed evaluation design and submission of reports of results will be submitted for CMS review. Comments on the draft evaluation plan will be provided by CMS within 30 days of receipt. Nevada will submit a final evaluation plan within 60 days after receipt of CMS's comments.

Upon approval, the State of Nevada will implement the evaluation plan and provide quarterly and annual progress reports.

## **WAIVERS AND APPROVALS REQUESTED**

### **Waivers Requested**

The State of Nevada requests that CMS consider the following waivers which are critical in order to permit Nevada to move forward with the innovative strategies outlined in the proposed NCCW, in collaboration with our CMS partners, and to prepare our State for Medicaid expansion under the Affordable Care Act in 2014.

### **Amount, Duration, and Scope of Services**

Section 1902(a)(10)(B) (i) and (ii) of the Social Security Act

The State of Nevada requests that CMS waive section 1902(a)(10)(B)(i) and (ii) of the Social Security Act to the extent necessary to enable the State to vary the amount, duration, and scope of services offered to individuals who are high-cost, high need Medicaid recipients (with certain exceptions) as described in the proposed NCCW, without regard to their eligibility category under the approved State plan, by offering cost-effective alternative benefit packages tailored to their unique health care needs under the innovative care management arrangements described in this proposal.

### **Freedom of Choice**

Section 1902(a)(23)(A) of the Social Security Act

The State of Nevada requests that CMS waive section 1902(a)(23)(A) of the Social Security Act to the extent necessary to enable the State to restrict Medicaid recipients' free choice of providers through the use of a mandatory enrollment and lock-in of certain recipients for specified periods in the care management arrangements as described in this proposal. The State is not requesting a waiver of recipients' freedom of choice with respect to family planning providers.

### **Payments to Providers**

Sections 1902(a)(13) (A) and (a)(30) (A) of the Social Security Act

The State of Nevada requests that CMS waive sections 1902(a)(13)(A) and (a)(30)(A) of the Social Security Act to the extent necessary to enable the State to determine appropriate Medicaid methods and rates of reimbursement with respect to the providers and organizations described in this proposal on an individual or class basis using the innovative payment reforms and performance incentives described in this proposal, without regard to the reimbursement methodologies that are currently specified in the approved State plan. The State requests that this also encompass a waiver of the requirements at 42 CFR 438.6(c) concerning actuarial certification of capitation rates solely to permit the appropriate substitution of best practices for more traditional actuarial certification procedures.

### **Authorization of Federal Financial Participation**

The State of Nevada requests that CMS authorize, under Section 1115(a) of the Social Security Act, expenditures that will be made by the State of Nevada in accordance with the aforementioned waiver requests and care management arrangements, which would not otherwise be allowable as expenditures under section 1903 of the Social Security Act. The State of Nevada

requests that, for the approved period of the NCCW, such expenditures be regarded as expenditures under the State's approved Title XIX plan.

### **Re-enrollment into the MCO of Record After 60 Days**

The State of Nevada requests that CMS waive Section 1903(m)(2)(H) of the Social Security Act, which provides that an enrollee who loses Medicaid eligibility for not more than 2 months may be enrolled in the succeeding month in the same MCO or PCCM if that MCO or PCCM still has a contract with the State. The NCCW would allow the State to re-enroll Medicaid recipients into their former MCO at any time, so long as the State still has a contract with that MCO. This would not waive the recipient's right to choice, as they would be allowed to choose an MCO at the time of application; the NCCW would only affect recipients who did not choose otherwise and would substitute a random selection with re-assignment into their former MCO. This would not waive the recipient's right to change MCOs for good cause. The State requests that this also encompass a waiver of the 60 day limitation at 42CFR 438.56(f)(2)(g)

## **CONCLUSION**

Developing a coordinated system of care that will improve the health of Nevada's high-need Medicaid population requires flexibility and innovation. The establishment of care management services and medical/health homes will help achieve these goals. Costs will also be reduced as a result of these programs, as providers will be able to spend more time focused on health prevention and maintenance activities and less time addressing health emergencies stemming from chronic conditions.

Moreover, Medicaid's enrollment will significantly increase in 2014, due to the ACA, which is why an intervention plan is needed now. Having a care management system in place prior to this date will allow for a more seamless transition into this enrollment expansion. The Nevada Comprehensive Care Waiver (NCCW) will provide Nevada with a foundation to create programs that will meet the needs of current and future recipients.

The Nevada Department of Health and Human Services, on behalf of the Division of Health Care Financing and Policy, is submitting this Section 1115 Research and Demonstration Project Waiver, called the Nevada Comprehensive Care Waiver, to the Centers for Medicare and Medicaid Service for review and approval.

Signed by:



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Michael J. Willden, Director  
Nevada Department of Health and Human Services

4-20-12

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Date

